report 2013

AN EXPERT PROJECT

>> DISMANTLING THE DEMOGRAPHIC BOMB

How to meet growing demand for medical services, taking declining income from contributions into account?

>> NO MORE QUEUES

Is it possible to deliver better quality and easier access to healthcare?

private HEALTH INSURANCE

Poland is on the verge of an important breakthrough. Over the next 20 years we need to reform the healthcare system, making it ready to pick up demographic, economic and technological challenges of the future.

Table of Contents

Introduction

The implementation of private health insurance is a "hot topic" in the recent years, especially now, with expected underperformance of public finances, announced budget cuts and recent implementation of the EU Directive on cross-border healthcare. In this situation, searching solutions that can add additional funding to the healthcare system, as other countries have done, seems to be the primary task of policy makers. Health has always been the value of very high importance for each person, regardless of their place of residence, religion or economic situation. The health of population reflects the state's wealth: usually poor means sick, and rich - means healthy. Of course, there is always not enough money in the healthcare, but we should try to find the balance between public and private resources and evaluate the effectiveness of the ways of spending them on basis of available data and indicators. Thinking ahead requires searching for mechanisms that would force high level of medical services and optimal spending of available funds - taking immediate needs of patients, medical standards and access to treatment into account. This report aims to bring together different points of view - of the academic experts, opinion leaders, managers, and professionals in the field of healthcare - in order to develop recommendations upon which the practical solutions for the Polish health system in the coming years will be based. All texts are independent elaborations of the authors and present a variety of opinions and solutions, making up full spectrum of views and recommendations of the experts involved in the project.

Karolina Pokorowska

Project Supervisor

The demographic situation as a justification for current and future health prospects in Poland

Professor Bolesław Samoliński

Head of the Department of Prevention of Environmental Hazards and Allergology at the Medical University of Warsaw, President of Polish Society of Allergology.

We are at the beginning of the depopulation of our country. According to the census of 2011, compared to the corresponding results of the census of 2003, the Polish population remained unchanged. We have 38 million people, of which 37 million are permanent residents of the country.

This statement, however, does not reflect actual demographic changes that have occurred over the past eight years, and have already emerged in the earlier period. The main problem is decline in fertility, combined with lengthening average life expectancy. In 2003 we have almost reached the safety limit for reproduction of our population. There were 1.3 children per woman in that time. Renewal of the population requires maintaining fertility rate at the level of 2.2 children per woman, and a drop below 1.2 may cause rapid demographic disaster, leading to the collapse of the country's security and economy. The phenomenon of a declining population of working age, and a growing population of retirement age is also a big challenge for the healthcare system, both from the perspective of the public payer and the organization and efficiency of the system. According to data of the Central Statistical Office and the Government Population Council, in about 20 years the population of our country will be reduced to nearly 36 million. There will be a further increase in life expectancy from 79.8 to 82.9 years for women and from 71.4 to 77.1 years for men. Therefore, the percentage of the population of retirement age will rise from 16% to almost 27%. Number of people over 75 years old will rise from 2 to 4.5 million, and their percentage in the population - from 6.4 % to 12.5%. So, the population of working age will be very close to the number of people of retirement age. Unfortunately, the difference in life expectancy between the sexes will remain. There will still be more single women, especially over 75 years of age. This will lead to mental problems, as well as those related to the daily functioning of elderly people. Currently, for each 100 men over 70 years of age there are as many as 180 women. At the same time, our society has a high percentage of people with disabilities (over 4.5 million). They comprise 12.2 % of the population.

Thus, the joy of living longer is being spoiled by a disturbing vision of an aging population, caused by shrinking birth rate. Currently, there are born 2 million children less than 10 years ago. The consequences of this fact are multi-faceted

IN SHORT

With fewer and fewer children born in Poland, the population is shrinking. Currently, we have 38 million citizens, and in 20 years' time there will be 36 million of us. On the other hand, life expectancy continues to grow. During the same 20 years the share of the retirement age population will increase from the current 16% to 27% and will reach a level close to the number of people of working age. We are being confronted with the vision of an aging society, constituted in a significant part by seniors. This situation gives rise to healthcare challenges. What's more, fewer people working in relation to the number of seniors will result in a fall of GDP and possible collapse of the healthcare system, or at least public debt that will charge financially the future generations.

Efficiency of the health system and its funding as a justification for the development of private health insurance

Professor Bolesław Samoliński

The efficiency of medical and social security of people approaching retirement age depends primarily on the organization of the health and social care, as well as the availability of financial resources.

Currently, the organization of the healthcare system does not see a problem of the elderly. In the public payer's policy this area remains beyond specific regulations. Seniors are left to themselves; they have no support from the National Health Fund and public healthcare. Their poverty leads to the need of saving at the pharmacy. They have no special rights, and are characterized by:

- poverty
- multiple morbidities and the resulting necessity of taking advantage of many medical technologies (including pharmaceuticals)
- reduction of intellectual capacity and mobility
- decrease in capacity of the senses
- disorders resulting from degenerative diseases of the central nervous system
- problems arising from the alienation from social and family life, manifesting mainly with depression

They are a particular social group that we will not only support financially by funding medical and social security, but also personally, through the family commitment to looking after parents, grandparents and great-grandparents. Poverty is a major determinant of life expectancy. Saving on pharmaceuticals results in a never-ending spiral of health deterioration, higher frequency of hospitalization and other medical interventions, thus leading to an increase in the cost of medical services provided to people over 65 years of age. Poland is a country located almost "at the end of the list" in terms of the number of years lived in good health. In contrast to Germany, France and other countries of the old EU fifteen, Polish seniors are ill and socially disadvantaged or even excluded. According to the data from the National Health Fund, the annual average costs of a patient over 70 years of age amount to over 4 700 PLN and are the highest of all age groups. These costs can be reduced by investing in promotion and preventive healthcare or different healthcare

organization, including development of an integrated multi-professional geriatric care, assigning geriatric beds in hospitals and clinics, or building healthcare centers. Creating long-term care policy cannot disregard the facts. Otherwise, the result will be the collapse of the labor market and a fall in GDP of 6% to 2% over the next 10-20 years. The system of healthcare will experience financial and organizational reduction and deterioration. According to CATO, the debt in the EU due to the aging of the population is over 400% of GDP growth. It is therefore a very important and growing burden on public finances, including public payer, which is the Polish National Health Fund. This situation leads to a debt that is and will be a burden for future generations and us. According to Professor Nojszewska, intergenerational obligations exacerbate the problem. " (...) In relation to 2007 off-balance sheet debt was four times higher than the official one and amounted to 182.8 % of GDP, so either all services should be reduced by 11%, or 5.5% of GDP each year shall be set aside by the public finance to meet higher liabilities in the future. Currently, only because of the above reason, every newborn should handle the discounted debt in the amount of 180,000 PLN and pay it." [White Paper on Healthy Ageing 2013].

Currently, public finance involves about 70 billion in health care. Economic and financial situation makes it impossible to increase this amount, basing either on the increase of health premiums or subsidies from the state budget. Thus, the financial security of future society must be dealt with in a different way, especially taking into account the rise of expectations due to civilizational development. The efficiency of the healthcare system based on fast, competent medical advice is essential also from the point of view of the professional performance of patients in their jobs.

Given the existing financial shortages in healthcare and the growing demand for new money, we should look for short-term and long-term solutions, which on the one hand will improve the health system, providing better and faster solution of health problems and offsetting costs resulting from absenteeism and presenteeism and on the other hand - will enrich it with new funds. Thus, we have to look for new solutions in the systems of health insurance and care.

Private health insurance (PHI) seems to be one of the best, quickly implementable solutions. It will in fact provide additional funding for the healthcare system and fulfil expectations of beneficiaries on the quality and availability, being also a "driving force" of healthcare. They provide an opportunity to satisfy the needs of public payer (ease the burden on the system and help it out financially), the service provider (get additional funds) and beneficiaries (provide prompt and competent medical advice). To ensure the quality of service, PHI should be a mediator between the healthcare provider and a beneficiary. At the same time it will allow for channeling private funds into the existing healthcare system, optimizing the cost of investment in health and starting competition, which will result in the realization of the slogan "money follows the patient".

Building a system of voluntary health insurance is also associated with an increase in capacity of the system of providers. This is because the queues to services financed only

with the NHF will shorten, for the patients taking advantage of medical advice within PHI will "come out" of the public system. Even today we can see the development of a system parallel to the NHF – based on so-called subscriptions.

IN SHORT

The aging population requires efficient organization of the medical security system and ways to finance it. The current system is not designed for this process. Older people, who suffer from poverty, diseases, loss of efficiency and loneliness, do not receive adequate support. Their poverty leads to saving on drugs, which in turn increases the costs of subsequent treatment in a hospital. The costs incurred for the treatment of a statistical Polish senior are high (over 4700 PLN per year), but can be reduced through preventive care. Each year the state spends 70 billion PLN on healthcare. This amount, due to economic and financial situation of the state, can be increased neither from the citizens' contributions, nor from the state budget. Therefore, we need to look for another solution that will improve the system. One of the best solutions is private health insurance. The people, who purchase PHI, will benefit from the services within it, thus relieving primary care - with the effect of reducing queues. The money paid by the insured under the PHI will also supply the public health service.

How have we coped with private health insurance in Poland? Are medical subscriptions its substitute or a permanent solution to the problem?

Professor Bolesław Samoliński

For several years, there has been a discussion on the variants of the introduction of private insurance in Poland. Whether it should be supplementary, complementary, or maybe substitute? The latter seem rather controversial. Today, in fact, 20% of healthcare system contributors supply 50% of its funding. Withdrawal of their contributions from the base health insurance (which probably would be the case with the introduction of substitute insurance) would not be appropriate from the point of view of social solidarity. We can also easily predict that the reduction in the financial resources of public payer (NHF) would lead to collapse of the entire system, with all its negative consequences. The state's care over the health of population would then virtually cease to exist and Poland would set back in social development.

The consequences would be much further. They would translate into the functioning of the whole of society, people of pre-working and working age, but before all they would affect seniors and their close families. This comment is important, because it answers the publicly appearing suggestions to market health services and the payer, bringing it to the model of early capitalism. The "invisible hand of the market" will not work in issues relating to health safety and can lead to the social and economic destruction of the country. Health is in fact a public good and its protection is the mission and duty of the state, which is the structure responsible for correct and safe development of the country. A reflection of this problem is a system of subscriptions, which developed in Poland as a form of filling the gap resulting from the lack of system and legal regulations of PHI. The system of subscriptions played a vital role. It was a driving force in shaping the health market, while creating security for meeting the needs of part of the population with higher income and having higher expectations in relation to the healthcare system. From a formal point of view, subscriptions are not insurance. Their essence is making systematic payments to the account of the provider, which in the short or the long term will cover the cost of received healthcare benefits. Depending on the size of contributions, they include a diverse range of health benefits. The subscription company is therefore not a mediator between the healthcare provider and a beneficiary, but the health institution

that receives in advance compensation from a potential patient and provides benefits only to the amount contributed by the fees. Furthermore, the universality and mass popularity of the services provided by subscription companies create a powerful health sector in Poland. This issue requires a delicate but effective analysis and providing solutions that will not destroy the achievements of the subscription system and at the same time will let PHI become a permanent part of Polish healthcare system.

A lot will depend on active and constructive attitude of subscription companies. Another problem is the question, which type of insurance should have a leading role in terms of the expectations of both the state and the beneficiary: supplementary or complementary ones. This weighty topic is discussed in another chapter, but in the beginning it is worth noting that PHI will succeed in our country only if it is universal, and the value of the voluntary insurance market is counted in billions. The more money flows into this system, the safer and more rational solutions will be designed for the potential patient. According to estimates by the Polish Chamber of Insurance, in 2011, the market of voluntary insurance and subscriptions reached 2.8 billion PLN and the insurance alone - 363 million PLN. There is so much left to do and achieve.

IN SHORT

In Poland in the last 20 years a system of private medical subscriptions, filling the gap between the needs of patients and the possibilities of the state system, has been created. The author draws attention to the fact that, from a formal point of view, subscriptions are not insurance, because they ensure benefits only up to the amount paid by the patient fees. The difference between subscriptions and PHI is the fact that in the latter system the functions of a payer and a provider are split. The author recommends reconciling these two different systems in a way that does not let destroy developing social capital associated with the subscription system. The author adds that the PHI will be successful only if it is widespread, because only the sufficient amount of money will allow presenting attractive alternatives to the patients.

Definition and comparison of the advantages and disadvantages of private health insurance

Witold Paweł Kalbarczyk MD

Definition

Private health insurance (PHI) comprises financial products that complement the range of mandatory health insurance. A space for them is created in connection with a basket of healthcare services provided under general insurance. There are two types of private insurance:

Supplementary insurance is providing faster access to health services that are in the basket of guaranteed benefits, but the access to them, due to the financial and organizational system shortages of publicly funded system, is limited. The relation of such insurance to the system financed by public funds is called "beyond".

Complementary insurance is supporting universal insurance benefits with its scope (fringe benefits insurance) or overlapping payments for benefits which are not 100% free for patients (e.g. drugs, medical consultations, above-standard lens or prosthetic joints). The relation of such insurance to the system financed by public funds is referred to as "over".

Krzysztof Łanda MD
Jakub Owoc PhD
Witold Paweł Kalbarczyk MD

Supplementary vs complementary insurance - the pros and cons

So far, the solutions more commonly offered in Poland are supplementary insurance and medical subscriptions. Although the latter ones are technically not insurance, it is no doubt that similarily to supplementary insurance they operate “beyond” the public system, providing its customers with easy access to many benefits that are hardly available in the system funded by the National Health Fund.

	Supplementary	Complementary
Against	Krzysztof Łanda MD • " They feed on " the deficit in the public system - the demand for supplementary insurance grows as the queues to "guaranteed " benefits, funded by the NHF, become longer - the worse is the situation in the public system, the better it is for supplementary insurance. • They relate mainly to a higher standard of service and faster access to outpatient services, which means they cannot solve problems associated with a deficit in the system. • They provide care "beyond" the public system without letting voluntarily insured patients resign from paying contribution to the public system, thereby they do not improve patient expenses.	Jakub Owoc PhD • Restrict access - as a rule, complementary insurance covers the cost of co-payments and the non-guaranteed services. • This means, that its real role in the system is determined by the existence of subsidies in the public system. They should be "insurable", which means they can not be insignificant. • An alternative to subsidies is reducing the guaranteed benefits basket, and again, this restriction must be factical, i.e. include services for which there is a real demand. • Both of these conditions mean that complementary insurance has a major drawback of a social nature: limited access to medical services financed publicly for those who do not have private insurance, which is usually the poorest part of the society.
For	Jakub Owoc PhD • Social solidarity - those with private insurance have access to benefits which are also guaranteed in the public system, so that they release public resources for people who do not have private insurance. • Faster access to services.	Krzysztof Łanda MD • More money in the system without the need to raise taxes. • Better access to health services in the guaranteed basket - for those who can afford to pay only the basic contribution and who benefit from free healthcare.

	• High flexibility - the products offered by insurers usually cover most scarce public services, so they can be quickly adapted to the imperfections and weaknesses of the public system.	• Limitation of the rationing of guaranteed services, corruption and the use of non-written "privileges" in healthcare, by removing the disparities between the amount of the basic contribution and the contents of guaranteed basket. • Increasing access to modern methods of treatment and innovative medical technologies (the number of those staying beyond the guaranteed basket will increase). • Providing access to technology outside the guaranteed basket (not included in the basic system), which in the case of illness, for example, it means receiving modern medicine. • Improving the efficiency of the use of private funds spent on healthcare. • Introduction of private insurance choices for citizens. • Introduction of competition mechanisms, both among payers and among providers. • The elimination or reduction of the shadow economy in healthcare. • Optional insurance with co-payments.

The most common myths concerning the private health insurance

Karolina Pokorowska

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So far, many myths and misunderstandings around the subject of private health insurance have grown in Poland. Which ones are most likely to recur? Why the beliefs, that have no reflection in reality, remain so popular?

Many argue that PHI will be available exclusively for the wealthy persons. But in fact it is quite the opposite – this insurance is designed in particular for less wealthy patients. Why? First, studies show that the proposed rates are considered affordable for most researched respondents. Second, PHI is more favorable than financing difficult to access services directly out of pocket, which today is the only option for those who do not want or can not stand in line. Third, in the context of legal regulation of PHI in Poland it will be possible to further reduce differentiation of prices of this insurance due to age and health status, as it usually occurs in the case of standard medical subscriptions.

The poorest patients - at the end of the queue

According to this myth, the existence of PHI will push the poorest patients even further in the already long queues to doctors and medical benefits, which in the context of theoretically universal, the same for all healthcare imposes additional divisions into "better" and "worse" patients. This myth feeds on the assumption that in the health system the queues form, because there are simply not enough doctors, health professionals and equipment. That is not true - there is just not enough money to be able to use medical services (e.g. to pay doctors for operations, to maintain the equipment). Thus, popularity of PHI is a way to shorten queues, because some of the people who take advantage of public health system will begin to receive benefits under the PHI.

More expensive medical services

There is a belief that the dissemination of private health insurance may increase the demand for all kinds of medical services, which - in accordance with the laws of economics - will raise their prices. But it should be noted that the increase in the price

of a good in the economy is caused by increased demand only if supply remains constant or grows very slowly. In the health sector however, once the PHI is introduced and more money appears, the supply of health services will automatically increase. Currently, due to the lack of money, a lot of services are not performed despite the existence of "spare capacity" (doctors, equipment, etc.). When the money flows into the PHI system, the spare capacity will be unlocked.

"Escape" of good doctors to private institutions

The mass popularity of PHI will lead to the development of private medical services market. Therefore, there is a wrong belief that most doctors would go to work in private offices and clinics, and for the patients taking advantage of basic healthcare system only the least competent physicians will be available. But the truth is that NHF will sign contracts with these private institutions for the implementation of benefits under the basic scheme. On the other hand, private insurers offering PHI will be able to sign contracts with public institutions (e.g. large hospitals), which in result will be better funded and able to employ good doctors. What's more, most doctors already work in both public and private institutions and it does not seem likely that after the introduction of PHI they are willing to give up part of their income (while in the public system they usually have more stable regular job).

Young people do not need PHI

Young people - generally fit and healthy - think that the problem of serious diseases does not apply to them. Especially in the Polish mentality, people believe that "young means healthy" and need for special care refers only to persons of advanced age. But the truth is that serious illness can affect anyone - this is particularly true of random accidents. That's why we need broad educational programs, mobilizing young people to take up prevention and start to care for their health, so that in older age they can still enjoy it.

IN SHORT

There are many myths on the subject of private health insurance. Patients are afraid that such a solution is available only for the wealthy ones and the poorest people would be pushed to the end of the queue. It is also believed, that the PHI would increase prices of medical services and cause the outflow of good doctors from public to private medical institutions. Young people are convinced that they don't need any insurance, because they will take care of their health once they are old. It turns out that all of those myths are false and lose the battle with the power of rational arguments based on facts.

Diagnosis of the healthcare market - condition of the healthcare system in terms of private health insurance

Waldemar Wierzba MD PhD

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If we want the private health insurance to fulfill its basic function, which is to support and complement the public system, it has to be popular among the masses. Thus, PHI must be attractive to the customer: be cheap and provide faster access to the benefits of better quality.

The number of Polish citizens is 38 511 800, including 19 868 000 women and 18 643 800 men (of which about 37 million lives on the territory of the Republic of Poland). Percentage of people over 65 years of age is more than 13% of the population and is steadily growing (declining proportion of people of working age). The country operates 830 hospitals (plus 42 branches), including 517 public and 313 private companies. They have a total of 184 514 hospital beds (i.e. 48/10 000 people), including 28 513 in non-public hospitals. Annually 8 054 336 patients are treated in hospitals (43.7 persons per bed). Annual treatment in hospitals is 44 701 900 person-days. The average length of stay in a hospital is 5.6 day. During the year, the bed is occupied for 244.5 days, which means the use of beds amounts to 67%. The primary source of funding for healthcare services is a contribution to universal health insurance. Planned revenue from those premiums in 2013 will amount to 64 237 866 PLN (steadily increasing since 1999). With the increase of funds in the system the spending by providers rises. The financial situation of healthcare facilities since 1999 has been always unsatisfactory. Despite the numerous restructuring activities (deleveraging), the debt of public healthcare continues to grow. The state of debt at the end of the first quarter of 2013 amounted to 10 741 300 PLN (including payables of 2 097 786 PLN).

Private health insurance is insurance guaranteeing the financing of healthcare services, not violating the rights and obligations connected with the state's obligation to provide universal health insurance and benefits guaranteed there. The primary function of private health insurance is to increase the amount of funds in the system of supplementing mandatory insurance. But this is not the only advantage of such a method of increasing the resources in the healthcare system. For private health insurance could fulfill its basic function (to support and supplement the public system) it must satisfy the condition of having mass popularity. It must therefore be attractive to the customer and cheap. But

what does the term "attractive" mean? For most people it will be a service delivered faster, having better quality and - most importantly - performed as close to the place of residence as possible (which is extremely important for the elderly, the lonely, for physically disabled and parents with small children). For private health insurance could satisfy this requirement, it must include in the offer such benefits that can be performed at the level of adistrict hospital, not only in highly specialized centers. When such a solution is possible, the mass development of PHI will be possible too.

The process of introducing private health insurance has one huge advantage - public health education. In Poland, unfortunately, people are not used to seriously "manage their own health" from an early age. The campaign around the private health insurance would perfectly complement and enrich the efforts of the medical community in the field of the promotion, for which there has never been enough resources (contrary - always far too little). Changing the attitudes of the society in this field is a long process, perhaps requiring a generational change, but definitely worth initiating as soon as possible. It is reasonable to claim, that the abandonment of the development of PHI puts the long-term efficiency of the entire Polish health insurance system into question. The question, that remains open, is which of the models of private health insurance - whether complementary or supplementary (or maybe simultaneous introduction of both models) - will be the most adequate to the Polish reality.

IN SHORT

Basing on the analysis of statistical data on Polish healthcare, the author states that systematically increasing number of people working in the health sector is able to meet the needs of the patients, however, the main problem are insufficient funds. Underfunding leads to debt and reduction in the quality of hospitals and medical services. The system therefore requires urgent changes. PHI would increase the amount of money in healthcare, without any negative impact on the basic insurance system. To work properly, private insurance should reach mass popularity – it means, they need to be cheap and attractive (medical services delivered faster, better and closer to home). The great advantage of PHI is public health education.

Prospects for the development of private health insurance in Poland

Witold Paweł Kalbarczyk MD

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In recent times there is a lot of discussion about the need to introduce regulations in order to develop private health insurance (PHI) in Poland. What conditions must exist so that it can be disseminated our country?

In Poland, the knowledge on private health insurance is still very limited, and we can even say that it is only available to a small group of experts. Once again in the recent 20 years we hear declarations from the ones that are in power, that it is high time to introduce regulations allowing the development of PHI in Poland, as it was done in many other countries around the world. It is then worth to bringing about this subject both to the group of decision-makers, and - above all - the public opinion. If this insurance is to be popular among masses and used by millions of Poles, the support for such solutions must also be counted in millions. The condition of making a decision to buy private health insurance is the knowledge that will allow for the wise choice of a financial product that guarantees the insured what they may need in the future in relation to their state of health. They should be conscious, that insurance is not a temporary solution, but a choice for many years - a financial product for which one has to pay regular premiums, even if the insured person is healthy and does not need medical examinations, consultations or procedures. With health insurance, the insured is protected from unexpected large expenses related to accidents or illnesses.

Basket of guaranteed benefits and private insurance

The range of the guaranted basket (all the benefits it includes), and the rules governing the use of services by entitled persons, determine the role and importance of private health insurance in any healthcare system. Basket of benefits in Poland is a positive one. Its content is specified by the Minister of Health in form of regulations to the act on health services financed from public funds. On this basis, we know what we get in exchange for the contribution to the basic system. Each basket, including the one with guaranteed benefits, has its own dimensions.

Basket dimensions are:

- width - defines who is insured and entitled to benefits
- depth - defines what benefits are included in the basket
- height - specifies the amount of costs that are covered by public funds

The observations of the Polish healthcare system show that our basket is far too deep against the other dimensions. There are a lot of benefits that can be theoretically used by almost all of the Poles, but unfortunately in practice, in large part, difficult to access due to the lack of public money. The inadequacy of the basket's depth to the amount of public expenses makes the realization of the constitutional right to public healthcare often practically impossible. To take advantage of this basic human right, while not breaking the others' laws to equal access to the publicly funded benefits, more and more Poles choose private medical services. In 2011, the amount of private expenditure on health, including health services and drugs (both paid ones and those reimbursed by the National Health Fund), was already about 33 billion PLN. In this amount, we have spent 14 billion largely on benefits that we are theoretically entitled to within the public health insurance. We pay for them twice, because the waiting time for them in public healthcare, in extreme cases, reaches 2 – 3 years; and 2 – 3 months of waiting for a specialist consultation is almost a norm. Private insurance can significantly improve this situation and speed up access to health services. Both in Poland and in the world a potential space for the development of private health insurance is ensured not by declarative, but the factical guarantee of availability of services.

The mass popularity of private health insurance

Complementary private health insurance can be a tool making co-payable or inaccessible for public money benefits available for everyone. If the space to be covered by insurance is large enough and the vast part of society is conscious of the financial risk, such insurance is likely to become popular in large scale, as in France, Slovenia, Ireland, Australia and the Netherlands. The complementary relation between the basket of guaranteed benefits and PHI (the "above" relation) is the only one that has a chance to achieve mass acceptance and become widespread. This is evidenced by the experience of countries mentioned above as examples. Supplementary insurance, as the British experience proves, is a good solution only for a few percent of the population, for whom faster access to benefits scarce in the public system (for which, as in Poland, there is no co-payment by patients) or the realization of benefits in a private hospital is financed by their employers. Insurance duplicating public system doesn't have mass character anywhere in the world, for a simple reason - even in rich countries, the so-called "Western" ones, few people are willing and can afford to pay twice for access to the same services, which should be available within the universal health insurance. In few countries that have developed supplementary insurance, they either face strong social resistance or - with the approval of the wealthier sections of society - at some point naturally suffer from the so-called "glass

ceiling" of development that does not exceed a few percent of the population. Such a situation can be observed in the UK, where in its peak period supplementary insurance was used by about 12% of the population, and now, due to better availability of services in the public system, this percentage has dropped to about 8% of the population. In Poland, subscriptions and insurance have already reached a similar level of development – they are used by about 7% of the population of our country.

Challenges of the future - the availability of services and the financial security

The degree of unmet health needs of Poles - measured for example by waiting times for health services and access to innovative drug therapies - is so large that an urgent action must be taken in order to change this. At the same time, demographic and epidemiological projections indicate that this problem will inevitably continue to grow. It therefore requires changes in the organization and financing of health services in Poland. One of them is the creation of legal conditions for the development for private health insurance at a mass scale. It should be both supplementary and complementary insurance and, above all, their mixture, providing quick access to health services needed by Poles. Private insurance for groups and individuals is an additional stream of money for health services for which people are willing to pay. In Poland, as in many countries around the world, the speed of access and quality of benefits are the main criteria for the selection of private health insurance. Legal conditions conducive to the fulfilment of such criteria by private insurance policies in our country will be of benefit to all Poles. The more people opt for such insurance, the greater this benefit will be. That depends greatly on the legal conditions created for the operation and development of PHI. The sooner this happens, the greater the chance of finding an effective "cure" to the Polish healthcare.

IN SHORT

PHI is an insurance product that complements and provides an alternative to universal health insurance. The latter includes in Poland defined, fairly broad basket of medical services, which are reimbursed from public funds. Polish basket is too deep - there are too many benefits theoretically available, but due to lack of money, hardly anyone has real access to them. That is why more and more Poles are treated privately. The solution to this situation can be PHI. Currently, there are popular medical subscriptions which fulfil a similar role (but not insurance) - provides faster access to better quality services. However, the author recommends the development of complementary insurance (with the addition of the supplementary one), because only this has the potential to become achieve mass popularity. This requires a space for its development.

The results of the social survey completed with the use of CATI metod

The survey was conducted by EU Consult Research in August 2013

There has been a public opinion poll conducted on the sample of 700 people about the use of healthcare. The respondents' answers are a basis to some interesting conclusions.

The draw of a research sample was made from among the database of telephone numbers, broken down by province. The size of the database was 1 040 000. The draw was conducted in a quota, taking into account the population size in particular provinces. As a result, the sampling was drawn in the size of 700 people, with an acceptable error of less than +/- 3.7% and 95% confidence interval. The study sample is dominated by groups of people from the regions of Mazovia, Silesia, Greater Poland and Lesser Poland. The minority of the respondents were from the following regions: Opolskie, Lubuskie and Swietokrzyskie. The most significant part of the respondents lives in cities, especially in those with up to 100,000 inhabitants.

The majority of respondents (29%) are those whose monthly income per person is between 1001-1500 PLN. They are followed by groups in which the monthly income reaches 1501-2000 PLN (22%) and 501-1000 PLN (21%). The smallest groups in the study sample consist of individuals with a monthly income of up to 500 PLN and those with more than 3000 PLN. Among the respondents, 11% refused to answer the question about the level of income, while for 6% it was difficult to determine its height.

In response to a question about the satisfaction from the public health system the vast majority of respondents - 61% - declared dissatisfaction with its functioning, while 39% expressed the opposite opinion. For questions about the actual use of health services, 62% of respondents declared that over the past year they have chosen private healthcare more often, while 38% - the public healthcare. In the case of using public health services, the majority of respondents (54%) said that they hadn't experienced any problems getting to a specialist. Other respondents (46%) met with difficulties in this matter. The waiting time for an appointment with a specialist, among those who said they had no trouble getting to the doctor was most often below 1 month. This opinion was expressed by 45% of the respondents. The lowest percentage of respondents - 19% - declared that the average waiting time was more than three months.

The vast majority of people participating in the survey (64%) knows the concept of the basket of guaranteed benefits, and is aware of its importance, while 36% have no such knowledge. In the case of private health insurance, the situation is slightly better.

Among the respondents, 72% said that they know this concept and they were aware of its importance. Such a large number of people declaring knowledge in this area may however indicate that respondents confuse PHI with the concept of medical subscriptions. Among those who are familiar with the concept, 73% believe that their knowledge in this area is complete and sufficient. There was also a question, how much money the respondent (whose expertise in the field of complementary health insurance was complete and sufficient) would be able to spend monthly on the insurance. The respondents prevalently indicated amounts below 30 PLN and from 30 to 50 PLN. The vast majority of respondents (82%) are willing to pay this amount for services that would reduce the queues in public healthcare and improve the availability of specialists.

The respondents would be also willing to pay extra for the guarantee of comprehensive medical care and visits outside queue in the event of illness (44%), for medical services outside the public healthcare system (17%), for improved availability of specialists (16%) or for access to the most modern, effective methods and technologies that are not funded by the National Health Fund (14%). The amount most often mentioned by respondents in case of the above benefits ranges between 50 to 80 PLN per month.

A significant portion of respondents would be most interested in a package for themselves and their family. In the next step they would be most interested in the packages for seniors and babies. The smallest group comprises the respondents who would be interested in other packages than those listed above.

IN SHORT

The survey shows that 61% of respondents are dissatisfied with the functioning of the public healthcare; likely large (62%) group of them chooses private treatment. Among those who use public clinics, 54% had no trouble getting to see a specialist, while 46% experienced some problems. Among the first group, the waiting time was usually less than a month. Most of the respondents know and understand the concept of the basket of guaranteed benefits and private health insurance. In the latter group as much as 73% believe that their knowledge in this area is complete and sufficient. Respondents argue that they would be able to spend up to 50 PLN on PHI. The vast majority (82%) would pay this amount for benefits that would help to reduce queues and improve access to specialists.

Results of the survey

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The interest in PHI grows among people spending more on out-of-pocket health benefits, but it is not higher than the average among ill people and those having children. This and other interesting conclusions result from the conducted surveys.

Research in the area of private health insurance is associated with different objective difficulties and so the results should be treated with caution. The first and main limitation on private health insurance is the lack of clear legal provisions. For this reason, there are obstacles in carrying out research in this area. Analyses indicate that the respondents' knowledge of the subject is quite limited. For the sake of previously mentioned difficulties in defining research problems, some of the questions used in the questionnaire are purely hypothetical, because usually the respondents did not know what exactly was meant by the term in question. What's more, the matter is additionally being complicated by regular media discourse on the need of introducing PHI, suggesting that such insurance doesn't exist in Poland at all, as well as the benefits and risks connected with the PHI, discussed by the politicians. In this situation, the form of a question being asked can have significant impact on the answer. If the question has a positive connotation and suggests some tangible benefits (e.g. private insurance for the higher quality of health services), the declared interest will probably be higher than in a case when the question has neutral connotation (e.g. general interest in PHI). It should also be noted that the Poles' opinion about the healthcare system is particularly bad, also compared to other countries, and for many years has been systematically deteriorating, which probably has an impact on the interest in solutions aiming to improve its functioning.

The studies had different assumptions about the research hypotheses, and therefore have different nature and content of the questions, and different assumptions about the sampling. These issues make it difficult to directly compare the results but allow drawing some general conclusions that may indicate a general attitude of respondents to pay for private health services in the form of insurance. The conclusions are based on the results of two detailed surveys, touching in details all areas related to the functioning of private insurance. The main conclusion from both studies is very low knowledge of the subject. Approximately half (49.3%) of respondents had never come into contact with the concept of private health insurance, and about two thirds (67.5%) have never received an offer to buy it. Both studies show the relationship consisting in the fact that greater knowledge of the voluntary health insurance occurs among economically active people from major cities, as well as those with higher income and well-educated ones. In both studies, we can notice strong support for the idea of private health insurance. As a part of the study, surveyed individuals were asked whether they thought there should be private voluntary health insurance. More than two-thirds of the respondents answered positively (definitely yes - 30.95%, probably yes - 37.55%) and only 13.08% were of the opposite opinion (definitely not - 3.80%, not really - 9.28%). Nearly one-fifth (18.42%) of the tested had no opinion on the subject. The second study provides similar conclusions. The surveyed people were asked the question: "Do you support the introduction of voluntary health insurance in Poland?" Affirmative response rate was obtained at the level of 40-75%, depending on the region. The greatest support for PHI was recorded in Warsaw and Gdansk (both over 70%), the lowest - in Poznan and the Zamosc region (40%). Both studies revealed a relatively high percentage of people who are skeptical about complementary health insurance (22-30%), but at the same time are regarding the possibility of taking advantage of them. The study also found that the main reason for lack of interest in private insurance is low knowledge of this subject. Among the skeptics there is a significant proportion of respondents having no clear opinion and knowledge of the subject (about 25% - 40% of respondents). High price is not such an important factor, though this argument is commonly used as a main argument against private insurance. By far, the most anticipated benefits from the introduction of private health insurance are: rapid access to specialized services and their high quality. Respondents do not pay attention, in turn, for example, to higher quality of the hospital stay. It is worth noting, that the basic needs related to the use of private insurance are related to the widely perceived problems of the public system, mainly limited access to services and long queues. In both studies we asked questions about the monthly premium that the respondents would be willing to pay for voluntary health insurance. The most accepted amount is included in the ranges between 21-50 PLN and 50-100 PLN, with men willing to pay more than women.

IN SHORT

The research shows that the actual knowledge of Poles about PHI is limited and unorganized. More than half of respondents have not ever heard of this concept (though better knowledge on this topic is noted among the employed, well-educated and well-paid

people living in the major cities), and about two-thirds had never met with an offer to purchase PHI. The support for the idea is generally high, and there are also a significant percentage of people skeptical towards PHI, but still considering buying them. Insufficient knowledge about PHI is the main reason for the lack of interest among the part of respondents – the reason more important than the price. People spending more on health out of their own pockets show more interest towards PHI. The interest isn't, however, higher among ill people and those having children. Respondents indicate rapid access to specialist services and their high quality as the main benefits of PHI. They are willing to pay up to 100 PLN for monthly insurance, and the men are willing to pay more than women.

Results of WHC BAROMETER 5/2/2013

Queues to the doctors are getting longer and longer. In June and July 2013, one had to wait for theoretically "guaranteed" health benefits for an average of three months. Compared to the previously analyzed period - the turn of February and March 2013 - this time has lengthened by 0.5 months.

Compared to the same period of the previous year (June and July 2012), the waiting time deteriorated by 0.8 months. A year ago, patients were waiting in line for about 2.2 months. The longest queue to health services is now in orthopedics and traumatology, where the waiting time amounts to 11.5 months (change from 12 months in February and March 2013), in ophthalmology, where one has to wait for 7.8 months (change from 4.9 months) and in angiology, where the waiting time is 7,2 months (change from 3.9 months). The greatest deterioration in the average waiting time for the whole area was in angiology, where the queue for the implementation of health services extended by an average of 3.2 months. Significant deterioration was also observed in ophthalmology, waiting for cataract surgery remains the most significant limitation. In February and March 2013 patients waited for this operation for 29.3 months, while the current time has extended by almost three months and amounts to 32.2 months - it means more than 2.5 years. In orthopedics and traumatology, despite the observed improvement in the overall waiting time for the whole area, we observe that the average waiting time for arthroplasty remains at a very high level.

Health benefit basket as a basic element of the healthcare system

Krzysztof Łanda MD

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Considering the size and the efficient management of the health benefit basket is essential for the regulation of the healthcare system and the functioning of health insurance.

Even the most developed and richest countries attach great importance to the efficiency of spending on healthcare, because - especially in view of the current rapid development of medical technology - any amount can be spent for that purpose. Efficient management of the health benefit basket is essential for the regulation of the healthcare system and the functioning of health insurance. Since health is a socially sensitive area, with a huge and growing importance to the economy, it is the correct definition in the system and efficient management of a basket of benefits that should be treated as one of the most important tasks of the state. Proper identification and effective management of a basket ensures:

- public health safety and sense of security of the citizens
- equitable access to health services funded by premiums of a particular type
- budget security and the rationality and transparency of public expenditure on health
- security of family budgets and the reasonableness of private expenditure on health

and also meeting the demands of sovereignty, solidarity and competition, while ensuring the efficiency of the health system.

Thanks to so-called “Basket Act” prepared by the Ministry of Health, signed in 2009 by the President of Poland, discussions about the need for creating a basket of guaranteed health benefits in Poland were once and for all cut off. The Act changed the perception of the eligibility for health benefits. The state of law existing before 2009 could be interpreted in accordance with populist slogans that "everything is for everyone", of course, beyond the negative basket, very limited at that time. Thanks to the Basket Act, some adequate regulations were introduced. They define the entitlement of the insured to particular

benefits from the guaranteed basket. This means that all the health benefits not mentioned by those regulations stay beyond the basket and cannot be financed by public funds (although they may be funded in a different way). The regulations include the following: treatment programs, outpatient specialist care, primary care, hospital care, highly specialized benefits, mandatory vaccinations, etc. The definition and management of particular parts of the basket in Poland still leave much to be desired.

The correct definition of health benefit basket in the system

"The basket definition" takes place on two levels:

1. internal, which relates to the construction of the basket (the characteristics, structure, content, creation and definition of elements) or baskets functioning in the country
2. external, which concerns the role and place of the basket in the health system

A health benefit basket is a set of healthcare services or medical procedures :

- that can be implemented within a particular type of health insurance (regardless of the method of financing these benefits) or
- have been excluded from certain types of health insurance

The guaranteed basket (otherwise known as a standard or basic) is a collection of healthcare services or medical procedures eligible under the basic health insurance. For obvious grounds, the guaranteed basket is positive. The primary function of the basked of guaranteed benefits is to describe the area of drug and non-drug technologies that can be done within the basic health insurance - regardless of the method of financing healthcare services. Basket serves the role of organizing and limiting the number of procedures and services, including medicines funded by basic health insurance.

The correct definition of basket of benefits in healthcare is not only a technical task, but also a political one, and therefore much more difficult than just improving the management of the basket and its specific parts. External and internal dimension of the basket should be dealt with at the same time, as they are dependent on each other. The role and place of the basket in the health system, determining its characteristics, shape and contents of the benefit package (and possibly other baskets), form a system and allow us to make certain changes or not. In other words, shape and content of the basket respectively correspond with the other parts of the healthcare system, or not. Difficulties in defining the basket are mainly due to the nature of health, as a good of particular importance for society and the individual, as well as the nature and diversity of health services. Number of medical technologies is enormous and estimated at tens or even hundreds of thousands. What is more, medical procedures are by nature difficult to standardize as many "clinical cases" differ from the norm and require a specific, non-standard treatment.

While the basket is always an important element of the system, it can not be assessed in isolation from the whole. As already mentioned, healthcare is an extremely complex system composed of many elements. In some very well-functioning systems, there are only private providers, or only private insurers. In other systems, also very well rated by the users, we are dealing with purely public providers and public payers. The world is very diverse in this regard, and private funds and resources show a full spectrum of possibilities. A large basket of guaranteed services without co-payments can function well in a single system, while in others not - it all depends on the type and relationship with other elements of the system. Equally well in one country a small positive basket, containing most of the defined elements, may play its good role in certain arrangements, while in another country a similar basket may completely not fit the other elements, and therefore evaluation of the system will be low, and its functioning wrong. In the latter case, we can either change the basket, or other elements of the whole, or both.

The role and place of the guaranteed basket in the system

The health system in Poland has long been insolvent, and the disparity between the ever-growing number of guaranteed services and the amount of funds from the primary health premium is growing. Queues are getting longer and longer. Rationing of healthcare services, even basic, effective and low-cost ones (with a very favorable ratio of cost to obtained health effect) is common. The limits to contracting benefits with NHF lead to lifelong debt of service providers and the formation of queues. Personal funds in healthcare amount to 30-40 billion PLN per year; corruption and use of the privileges are a norm. According to the assumptions, we can distinguish four basic ways of dealing with the deficit, meaning the discrepancy between the contents of guaranteed basket and size of public funds needed for its implementation:

1. Significant increase in the size of the primary health contribution
2. The introduction of high co-payment
3. The removal of many medical technologies with low profitability from the guaranteed basket (relatively high cost compared to the benefits derived), including the obsolete ones
4. The introduction of complementary health insurance

The basket definition can be carried out in an evolutionary way, being the result of deliberate actions taken by governments in a planned manner, as was the case, among others, in Australia, the Netherlands, and Switzerland. But the basket can also be a result of more or less random events in the history of the system, so as a result of more or less deliberate, correct or wrong decisions of actors of the system, such as occurred in the last 15 years in Poland. The need to ensure the stability of the law is beyond the discussion, otherwise the private insurance market in Poland will not be attractive for serious investors. Also, for the operation of the basket of guaranteed services in the health system, it is essential to define a framework for the regulatory role of the state with respect to general insurance market, in relation to complementary insurance. The need for rational

control due to the unique characteristics of healthcare services market in the world today is out of the question, taking into account both the positive examples of regulation in countries such as the Netherlands and Australia, as well as negative examples of selective regulation such as the United States.

IN SHORT

The health benefit basket is a set of services, treatments and medications that the patient is entitled to under a specific medical insurance (positive basket) or is excluded from them (negative basket). Efficient management of the basket helps to maintain public health security, equitable access to the benefits, good management of the state budget and household budgets. The Basket Act from 2009 settled the rules for definition of the volume and content of the guaranteed basket. The difficulties of defining the basket stem from the multitude of medical procedures, the significance of the subject of health, and the fact that medicine does not easily subject to standardization. There is no "perfect basket" - it should be always adapted to the conditions and needs of the system. If in the healthcare, as it is in Poland, there is not enough funding for the implementation of services within the guaranteed basket, it is possible to increase the contribution or introduce co-payments, reduce the basket or introduce complementary PHI.

NHF budget on the basis of GDP - the estimated needs for 2020. Does the budget meet the increasing importance of the demographic factor?

Michał Pilkiewicz

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Poland is a country that in comparison with other European countries has one of the largest potentials of growth in demand for healthcare, funded both by the state and by the patients.

The possibilities of the state budget for the financing of healthcare are influenced by various factors. The most important of these are changes in demographic and income structure of the society as well as the process of development and popularization of medical technology.

The demographic factor

In the coming years, a proportion of older people will increase: the number of people aged 65+ will grow from 5.1 million in 2010 (13% of the population) to 11.3 million in 2060 (more than 34 % of the population). The percentage of people of working age (20-64 years) will drop from 65% in 2010 to 49% in 2060. In 2010, for one person aged 65+ there were about five people of working age. In 2060, for one person aged 65+ there will be only 1.4 people of working age.

The analysis of the European Commission report shows, that the aging of the Polish population is extremely fast, compared to other EU countries. Healthcare expenditures increase with the age of the patients. The data by the National Health Fund show that the average cost of a patient under 64 years of age in 2011 amounted to 1 200 PLN. But maintaining the current structure of the drugs availability and morbidity, the aging of the population will lead to increased financial needs of the patients and the National Health Fund and eventually will lead to the changes in the structure of demand for health services.

Population in Poland, 2012-2020

The increase in the number of older people will increase morbidity, which in turn will change the structure of prescription of drugs available in the pharmacy. This will result in increase in cost of reimbursement of prescription drugs and those co-financed by the taxpayer. In addition, older patients and their children, often funding treatment of their parents, will spend more on drugs. An aging population will have a direct impact on public finances - in the form of increased costs of healthcare and care for the elderly. This growth will be driven by the dissemination of diseases such as diabetes, hypertension, cancer, osteoporosis and respiratory diseases.

Analysis of the osteoporosis drugs market as an example of the demographic factor effects

An ageing population will increase the dissemination of bone diseases, including osteoporosis. Currently, the structure of prescriptions for drugs against osteoporosis shows that over 88% of them are prescribed to women over 60 years of age. By keeping the price level of 2012, we can forecast that due to demography the market for osteoporosis in 2020 will record 21% increase in value, compared to the level in 2012 (sales from wholesalers to pharmacies, net producer prices). Impact of demographics on the size of the drug market for the disease in the years 2012-2020 will be higher by 8% than in the years 2005-2012, when it was 13%.

The income factor

With the growing affluence of the population, spending on healthcare increases. Furthermore, spending on health is growing faster than income, because people are willing to allocate an increasing share of their income for this purpose. According to CSO data, the ratio of health expenditure to GDP in Poland has increased in the period 1990-2010 from 4.8% to 7.0%. However, the forecasts of the European Commission imply a reduction in economic growth, inter alia, as a result of the demographic crisis and reduced number of people of working age. Along with the decline in economic growth we should therefore expect cutting back on healthcare in rich countries, both in the segments of public expenditure and private spending (out-of-pocket). In developing countries - such as Poland, where we have to deal with expenditure on health *per capita* lower than the European average, the pressure will be even greater in the context of the protection of basic health needs of patients and the financial capabilities of citizens and the state. The decline in economic growth and the demographic crisis (increase in the number of older people 65+ and reduction in the number of people of working age) can increase morbidity, especially among the elderly population (65+), which by 2020 will grow by nearly 30% compared to 2012.

The technological factor

The development of medical technologies and innovative approaches to treatment is responsible for much of the increase in spending on healthcare, especially in developed countries. In Poland, the expected impact of technological factors and increasing access to more innovative forms of therapies will be less relevant in comparison to the challenges associated with an increase in state and patients expenses due to the influence of the demographic factor.

Applications

The increase in demand for health services in Poland will be one of the largest among the countries of the EU. The main source of funding health is public money. In 2010, the share of public expenditure in Poland amounted to nearly 72%. However, despite the growing needs shown above, in terms of current and projected macroeconomic situation, a substantial increase in public expenditure on healthcare is unlikely. Based on the available data on the projected GDP for 2020, and given the assumption that the National Health Fund expenses as a percentage of GDP will remain at an average of 3.8%, and the percentage of the budget allocated to the National Health Fund medicines will remain at 11%, it can be concluded that the expenditure on public health and medicine in 2020 will be worth more than 93 billion PLN, and for drugs only - about 10 billion PLN. Expected values - 93 billion and 10 billion PLN - should help maintain the current level of access to treatment and its present standards, assuming an unchanged structure of morbidity and guaranteed services. However, demographic changes, increased incidence of lifestyle diseases and chronic diseases, as well as the access to innovative medical technologies are the factors that will influence the growth of health spending. We are already in a situation of a noticeable increase in spending on drugs and chemotherapy. Thus, the expected amounts have to be relatively higher. Is this possible in the current and projected economic situation in Poland? It seems that the private health insurance is one of the factors that may affect the improvement of access of patients to treatment, without increasing private spending drastically. Patients - as shown by the analysis - are already the main source of growth of the pharmaceutical market. Limited possibilities of increasing the public spending, increasing level of patients' expenditures for both subsidized drugs and other medications require – like in other countries - the introduction of additional, third source of funding. It would increase the amount of resources available in the system of healthcare financing in Poland, including expenditure on reimbursement of medicines. The current situation on the market of drugs available in the pharmacy shows that by 2012 the market growth was mainly "funded" by private funds - the patients – what was essentially influenced by the reform of 2012, reducing NHF expenses for reimbursement of medicines in pharmacies from 8,8 billion to 6.6 billion PLN - the amount of the years 2006 and 2007.

IN SHORT

The main factors behind the increase in spending on healthcare in Poland are: ageing population (in Poland extremely fast in comparison with other EU countries), increasing wealth (which translates into a greater interest in health), and the development of technology and medical knowledge (better and more expensive treatments). Ageing of the population will lead to increased expenditure on health and also other structure of benefits - more money will be spent on diseases typical of old age. The increase in demand for health services in Poland will be among the largest in the European Union.

Impact of private health insurance on healthcare market

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Private health insurance will not operate in isolation from the public health system, but will have a significant impact on its key elements.

In the context of limited opportunities to increase public spending on healthcare, we can take action to optimize healthcare financing from private sources. Private health insurance should bring benefits not only to the patients. PHI beneficiaries must also be doctors, healthcare providers (ambulatory and hospital care) and - indirectly - the employers. Only in the general context of wider availability of improved healthcare services, it will be possible to obtain the parameters necessary for the full development of private health insurance.

The benefits for the patient should be:

- protection against incurring further out-of-pocket expenses
- shortening the waiting time for guaranteed health benefits
- higher quality, availability and wider range of medical services
- greater choice of providers
- a sense of security in access to healthcare

Improvement - in the long run – of the patient's condition, resulting from the above advantages will bring additional positive impact on the labor market and employers in the form of shorter and less frequent sickness absence or reduction in the number of people unable to work. This will be particularly important in the context of the extension of the retirement age and a likely decline in the number of people of working age. Soon, every person who will be able to work - regardless of age - will be fundamental for government spending in the maintenance costs of the pension system. The influx of additional funds will enable the health system to provide more medical services, which will contribute to the improvement of patient care and hospital treatment without having to reduce their numbers, but rather by focusing on optimizing operations and changing the scope of services. Regulation of the principles of cooperation between the providers and the payer is also significant. Improving the financial situation of providers will result in the

possibility of achieving higher incomes and better working conditions by the medical and non-medical staff. At the same time it will provide the physicians access and the ability to perform additional tests, which are often necessary in making a proper medical diagnosis. This will also have the effect of lowering the total cost of treatment. Analyzing the benefits of introducing PHI, we must ask a few questions: what, how and how fast should be done to give PHI a chance of success in Poland. Now we are at the verge of regulatory changes and still lack guidelines that would allow for an accurate assessment of the impact of private health insurance for the pharmaceutical market and the healthcare system. Looking at the solutions adopted in other countries, it seems that the universality, comprehensiveness, transparency and competitiveness of the PHI system will guarantee success.

„Global opportunity to improve responsible medicine use" – how to spend money on drugs more effectively

Michał Pilkiewicz

Not knowing the assumptions associated with the introduction of private health insurance, we should also look for other solutions. An alternative to the PHI can be optimized management of medicines.

These solutions have been presented in the report, which was created for the purpose of the meeting held at the end of 2012. On October 3, 2012 in Amsterdam there was a congress of International Pharmaceutical Federation (FIP) Centennial Congress and Health Ministers Summit Event under the auspices of the Dutch Minister of Health and Sports, Edith Schippers. The meeting was entitled *"The benefits of responsible use of medicines. Setting policies for better and cost effective healthcare"* and attended by over 30 ministers of health. The main topic was the issue of so-called "lost opportunities". This term is associated with the misuse of drugs, which derives inter alia from erroneous ordination of drug or dose selection method or the regularity of taking it by the patient. As a result, many diseases are treated in disaccordance with accepted standards. The consequences of these shortcomings are being felt not only at the economic level, but also have an impact on the health of the patient. IMS Health and the World Health Organization have been invited to attend the meeting as experts in these matters. For the purpose of this meeting, the IMS Institute for Healthcare Informatics prepared a report on the responsible use of medicines. The study also addresses the issues related to the optimization of expenditure on healthcare. It is estimated that the optimization process would reduce the global cost of "lost opportunities" by 500 billion USD. More information about the publication can be found at www.responsibleuseofmedicines.org. The solutions proposed in the report relate to the areas of reimbursement and are based on a set of criteria that meet the following assumptions:

1. Low level of expenditure on implementation.
2. Moderately or significantly improved health outcomes.
3. A short time of achieving the impact.

As a result of the analysis conducted by IMS Institute for Healthcare Informatics, there were identified six key areas where it is possible to implement measures that can contribute to the rationalization of expenditure incurred on the purchase of medicines.

These areas include:

1. Unnecessary use of drugs.
2. Medical errors.
3. Improperly conducted polypharmacy.
4. Suboptimal use of generics.
5. Improper or excessive use of antibiotics.
6. Failure to comply with treatment recommendations.

The next step of the analysis was to create for each of the areas the appropriate and practicable recommendations that in the short term would bring a positive impact in the management of medicines.

There are five key recommendations that require low-level inputs, yielding significantly better health outcomes and having a short time to observe the impact.

1. **Promoting a greater role of pharmacists in the management of medicines for patients and their collaboration with physicians when making changes.**

   - Noticing the important role of pharmacists that they can play in collaboration with physicians in the management of medicines in health centers or in an outpatient setting
   - Encouraging pharmacists to provide the doctors with regular up-to-date information on drug therapy
   - Supplementing and adjusting regulations or financing mechanisms to pay pharmacists for working time designed for inspection of drugs
   - Use of pharmacy data on issued drugs in order to monitor medications
   - Supporting rapid decision-making and interventions based on data showing the needs of the patient and health outcomes
   - Using mobile phones by pharmacists in order to communicate with doctors and patients to discuss the treatment regimen changes or to remind about taking medication
   - Employing some pharmacists in the doctors' workplaces to evaluate the real-time use of medicines and provide advice regarding patients with complex treatment regimens
   - Providing training for pharmacists to improve their communication skills with the patients

2. **Investments in medical audits for older patients with a higher likelihood of receiving multiple medications.**

   - Collect data on regimens of older patients. In countries where there are electronic health management systems (e-health), all elderly patients, along with their medical histories, are registered in the system. This gives the opportunity to identify elderly patients at risk of side effects of polypharmacy. Data provided by pharmacists can be used to monitor elderly patients taking multiple medications.
   - Audit and feedback can be of managerial or regulatory character, or may be used for accreditation or organizational assessments.

3. **The introduction of mandatory reporting on the use of antibiotics by a healthcare provider.**

   - Creating a self-reporting system for the prescribing doctors, to report the level of own prescription of antibiotics
   - Following the issue of antibiotics in order to monitor their sales; analysis of cases of sales without prescription (if applicable)
   - Analyzing trends in the use and resistance to antibiotics - the use of scientific evidence to update the guidelines
   - Establishing national guidelines or regulations implementing the reporting requirement for a hospital or individual antibiotic prescribing
   - Analyzing reports on a monthly or annual basis in order to track changes in the trend and study periods or regions with a high level of prescriptions
   - Analyzing reports in order to compare practice with guidelines

4. **Promoting positive attitudes and culture in relation to reporting errors by reducing penalties against beneficiaries making mistakes.**

   - Adopting the official policy of the hospital on complete openness in reporting errors with respect to patients, along with amendments to the relevant provisions relating to liability
   - Establishing hospital policy actively encouraging the reporting of errors by healthcare professionals
   - Encouraging all employees in the health sector (doctors, pharmacists, nurses and others) to participate in the reporting of medical errors
   - Creating a system for reporting errors at the hospital and the country level
   - Promoting the use of the system among healthcare workers and increasing their awareness of the available channels to report errors
   - Educating health professionals about how to reduce the level of errors thanks to updated information and trends concerning medical errors

5. **Support for targeted treatment programs for key non-communicable diseases (diabetes), in order to ensure adequate time of therapy initiation: not for all patients, but for those being most at risk**

- Creating an online database to record and track information for patients and to identify patients with the highest level of risk
- Generating reminders for providers (concerning the progress of patient treatment) and patients (for overdue research and visits)
- High-speed automatic offers of treatment in a situation of an increase in the patient's specific physiological parameters to the threshold values
- Encouraging physicians, pharmacists and nurses to participate in programs of treating diseases
- Getting support from local hospitals and specialty pharmacies and laboratories

The introduction of these recommendations will help to alleviate the growing needs in healthcare, through the optimal use of available public resources. Financial and health benefits obtained as a result of these activities (for example, patient education, fewer side effects as a result of reduced polypharmacy, appropriate initiation of treatment) will help to address the current limitations in access to healthcare, resulting from long waiting times for health services and poor coordination of patient care.

Legal framework for private health insurance

Marcin Matczak SJD

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Private health insurance is a rather complex issue from the legal point of view, especially taking the constitutional law into account. This statement is the answer to the question, why we are not legally able to normalize the PHI, although there have already been a few attempts.

The provisions of the Constitution do not directly regulate the introduction of private health insurance, but the appropriate adjustment must be in line with art. 68, which provides for the right to healthcare and the duty of public authorities to ensure equal access to healthcare services financed from public funds, as well as with the principle of freedom of establishment (article 22 of the Constitution) and the principle of acquired rights and freedom of contract. It should therefore be first to the question whether the provisions of the Constitution allow for the possibility of introducing private health insurance, and if so, what conditions should be met by the relevant regulation. The doctrine suggests that art. 68 par. 2 does not close the way to the introduction of private health insurance, if the existence of such institutions will not lead to the withdrawal of the state from its obligations provided under article 68 or to unequal treatment of persons entitled to take advantage of the standard benefits. This position was also confirmed by the Constitutional Court in its judgement K14/03, which specifically referred to the possibility of introducing private health insurance. According to the Court's opinion, it should be noted that the Constitution does not prejudge the structure of the health system as a whole, but it establishes a factical obligation for public authorities to ensure the realization of the right to health. This obligation, however, can not be regarded as an illusory or purely potential right, and the healthcare system as a whole must be effective. In this judgement the Court explicitly pointed to the possibility of private insurance, if as a result of its introduction there will be no violation of the right to health of each individual. Referring to the constitutional provisions and the observations of the Court contained in the said judgment, the introduction of private health insurance may not affect the implementation of the obligation to provide equal access to healthcare services financed from public funds. This means that the private health insurance may not lead to

omitting the queues for services that are publicly funded. Moreover, in accordance with constitutional requirements, this matter should be regulated by law, to ensure maximum security for beneficiaries of the healthcare system. Finally, we should point out the need to establish a clear, precise and functional structure of the health system, which is derived from the principles of good legislation. At the same time, this design must take into account other constitutional principles of freedom and, in particular, the principle of freedom of contract and freedom of establishment. Thus, the introduction of private health insurance is acceptable and can even be argued that it is desirable in the light of the constitutional framework. Its introduction in fact contributes to more effective healthcare system, which means a better implementation of the state duties of ensuring the right to health.

Analysis of existing ideas and legislative proposals

Marcin Matczak SJD

The following will discuss the concepts that were developed so far, but have not been finally implemented.

The first attempt aimed at introducing private insurance as an alternative to universal health insurance. In an alternative system, also called substitutive, the private insurer provides access to healthcare services for persons excluded from the public system. The aim of this system was to establish a competition for the Healthcare Funds. In this project, health insurance institutions were to provide not less than the range of health benefits guaranteed by law, cover all those who register and not differentiate premiums, operate throughout the country and include family members of the contributor. Starting operations by a health insurance institution would require the approval of the Health Insurance Authority - the body responsible for protecting the interests of the insured. The relevant regulations have been adopted in the Act of 18 July 1998 amending the law on universal health insurance and on amendments to certain laws, but before they came into force the policy-makers had already changed the approach to PHI. Article 4a, which in the form of 1998 set insurance institutions competitive with the Healthcare Funds, had been already changed and stated, that the universal healthcare insurance outside the Healthcare Funds would be regulated by separate act. The idea of substitute health insurance was withdrawn particularily due to lack of maturity of the insurance market and lack of determined basket of guaranteed services at that time. Then, an attempt was made to settle the issue in the project of the Parliament in 2008, which provided for a mix of supplementary and complementary system. The proposed solution significantly differed from the previously accepted concept. Now the bill regulated private, voluntary health insurance as complementary to general insurance, rather than to its competitors. This meant that the insured would continue, regardless of the private health insurance, to be insured under the general scheme. Supplementary insurance, according to the draft, would secure guaranteed access to health care services, of which the insured could resign under the terms of the Act - prior to starting using the benefits one should indicate under which insurance it would be undertaken. Meanwhile, the complementary insurance would provide the insured the access to benefits remaining outside the basic basket or finance part of the cost of partially guaranteed benefits. The act settled general principles of functioning of private health insurance, which had to be under the oversight by the Health Insurance Authority. This project, however, did not provide any financial incentive to contract private health insurance with the exception of insurance funding opportunities from the Employee

Benefit Fund. The provisions of this project required clarification and development, but the Health Committee did not eventually work on it. In 2011, the Ministry of Health has developed so far last bill concerning the private health insurance. The project aimed at standardizing the issue of private complementary and supplementary health insurance in Poland, understood as the insurance products that may be purchased on a voluntary basis alongside the public health insurance. General objectives of the project were therefore similar to the project in 2008. People who have concluded a contract with the insurer should continue to be covered by public insurance. In the case taking advantage of guaranteed benefits, the costs of these benefits were to be charged to the contract with the insurer. The project of 2011 indicated that the performance of the contract with a private insurer can not affect the implementation of guaranteed benefits, publicly funded, which means that all the people were supposed to have equal access to the benefits guaranteed and implemented under contract with the National Health Fund (one waiting queue). Such regulation should be assessed positively in terms of the obligation to ensure equal access to the benefits referred to art.68 par.2 of the Constitution. We should also positively refer to defining the subject of the benefit provided by the insurer - not meant to be just the funding of benefits, but could also include the provision of healthcare services. Provided incentives to enter into private health insurance, such as tax relief for financing such insurance and the possibility of spending money on insurance from the Employee Benefit Fund, are also noteworthy. However, this draft provided a number of solutions that raised important questions and were seen as barriers to the development of private health insurance in Poland. In particular, we are talking about:

- It granted very broad powers of supervision and control of NHF over providers, which meant that it might affect the functioning of other payers - private insurers. A much better solution was previously proposed creation of a separate administrative body to supervise the health insurance market.
- It introduced absolute prohibition on contracts between NHF and healthcare provider after a similar contract had been already dissolved three times for breach of rules on waiting lists. This seems to be contrary to the principle of freedom of contract.
- It obliged providers to complete the contract for the provision of healthcare from the National Health Fund at the level of 90%. It seems that this requirement was aimed at ensuring accurate delivery of benefits guaranteed under the contract with the NHF. However, this solution was completely incomprehensible, because its aim has been already achieved by the above standard for a single queue.

As we can see, the current proposals for the shape of private health insurance are different from each other, although the latter two projects provide the same kind of PHI. The justification of the latest project indicated the need for additional regulation of the health insurance sphere. It is hoped that in the near future the works on standardizing this area will result in the adoption of an act taking into account past experience. In particular, the rules, irrespective of the type of private insurance system, should not make too

far-reaching restrictions for cooperation between the insurer and the provider, which can especially be seen in the draft of 2011.

IN SHORT

PHI is a complex issue, still not fully regulated by law, despite many attempts to introduce such regulations. In the light of the Constitution, the rules must be consistent with art. 68, which guarantees the right to health and equal access to healthcare services financed from public funds and with the principle of economic freedom, freedom of contract and acquired rights. The Constitution defends the right of citizens to effective healthcare - PHI can't mean patient preference in the basic system. The first idea was the substitutive PHI system, being an alternative to a general obligation of insurance. A parliamentary project of 2008 provided for a mix of supplementary and complementary system. In 2011 there was a project of the Ministry of Health, which regulated issues related to the PHI. The project touched vital issues, however, contained a number of controversial specific solutions.

Implications of Cross-Border Directive

Krzysztof Łanda MD

Karolina Skóra

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Directive of the European Parliament and of the Council 2011/21/UE of 9 March 2011 on the application of patients' rights in cross-border healthcare stays in force in the European Union since 25 October 2013.

The aim of the Directive is to eliminate barriers in access to healthcare, under existing European borders. Inevitably, the directive will lead to a reduction in disparities in access to key health services between EU Member States. It will mainly hit into the limitation of access, taking the form of queues and resulting in limiting basic specialist services for payers. There will be no restrictions in the areas of patient care and the benefits provided on one-day basis. Member States may however introduce a system of „prior consent of the payer" on the flow of patients in three cases:

- services that require to stay in hospital for at least one night
- highly specialized and costly services
- in certain justified cases of doubt as to the quality or safety of care abroad

Until now, the Poles rarely took advantage of treatment performed abroad because they would have to cover 100% of medical expenses out of pocket. After October 25, 2013, the situation is quite different. With the introduction of the Directive, patients are entitled to receive healthcare in another EU country, and the value of the refund is equal to the one that a patient receives in their home country. So, Poles can be treated abroad, and the National Health Fund will have to pay them such amount, that is reimbursed for that benefit in Poland. The barrier to access to health services will be then reduced, since in many cases the patient will pay only 5%, 10%, or 15% of the cost of the service - the rest will be refunded to him. This will significantly affect the growth rate of demand and use of the rights acquired by the Directive. There are currently branches of medicine in Poland, in which patients do not experience any access restrictions in the form of queues to important health benefits. For example, the average waiting time for hip arthroplasty was in June 2013 almost 2.5 years (28.9 months), and urgent knee joint replacement - nearly 20 months. So if a Pole wishes to take advantage of hip replacement surgery in Germany, he will have to pay 10-15% or even 20%, while the rest will be returned to him by the NHF, hence the demand for benefits abroad will increase significantly. In addition, some

procedures in Poland are priced much higher than in neighboring countries - such as cataract surgery. In this case, the NHF will have to pay the full amount for medical treatment abroad. In view of the fact that Poland has not finished in time the implementation of the law relevant to the functioning of Cross-Border Directive, there are currently no reasons to require the consent of the National Health Fund for any hospital services. Lack of such a law means that all the benefits provided under the guaranteed basket (including all hospital procedures) can be performed abroad, and the payer would have to pay for them - up to the valuation in Poland. Even if the law will come into force in the spring of 2014 and reduce the number of hospital services, NHF still will have to pay for the services performed by that time, because the law is not retroactive (*lex retro non agit*). Despite the media declaration that the National Health Fund will not pay any money for treatment before the entry of a specific law into force, we should be aware that the Directive as a provision of EU law has primacy over the national law and the NHF will in fact have to pay money to patients. If, however, the NHF actually will not have paid the costs of medical care abroad, the avalanche of lost lawsuits related to claims would result in even greater costs incurred directly from the state budget. Despite the risk of insolvency of the NHF, the Poles can enjoy the rights conferred by the Cross-border Directive – it is a very important driver of real, deep and significant changes in the healthcare system in Poland. It seems that this time, the NHF will be "dethroned" and lose its dominant position in the system, and the patient will finally (and indeed much more) be in the center of the system and the focus of politicians. The Directive and, consequently, the abolition of quotas, will improve access to treatment for the poorest people who can not afford now to use private healthcare. NHF will be forced to finance the most important social benefits in accordance with the needs, and thus improve the availability of doctors. In addition, the introduction of Cross-border Directive, thanks to the European reference networks of providers in the knowledge centers of the Member States, will contribute positively to the development of diagnostic and treatment capacity.

IN SHORT

Cross-border Directive of the European Parliament from March 2011, on the application of patients' rights in cross-border healthcare, is in force since 25 October 2013. Thanks to it, patients may be treated abroad and the payer will pay an amount equal to the valuation of benefits, as applicable in the EU country. Until now traveling for medical purposes was not popular among Poles, because they would have to pay 100% for the benefit abroad. In the light of the Directive, they will pay only a few percent of the price or even nothing. Despite the threat, that the NHF will be insolvent in the long run, the Directive will have a positive impact. Patients will get more choice, the availability of doctors will improve, and the less well-off patients will not have to choose between the pocket drain and waiting in long lines. In addition, the Directive will contribute to the cooperation between European countries in terms of health.

Global trends in the field of private health insurance

Jakub Owoc PhD

Due to the uniqueness of each healthcare system and the fact that private insurance is always adapted to local characteristics, the classification of health insurance is complex and it is difficult to speak of universally effective solutions. Each country is seeking its own path.

This path is ultimately the result of the experience, resources available and - perhaps above all - politics. Within countries, there may be also different types of private insurance, and the differences between them are often blurred. This is best illustrated by a classification of private health insurance made by the Organisation for Economic Co-operation and Development (OECD) and the European Commission and London School of Economics. Apart from differences in the number of categories of insurance (OECD - 5, European Commission / LSE - 3), the contradiction of definition for supplementary insurance is worth noting. According to the European Commission, it covers the benefits guaranteed already in the public system, while the OECD has quite different views - supplementary insurance covers services excluded from the public basket. Interestingly, in the dictionaries of synonyms Polish words "suplementarny" (supplementary) and "komplementarny" (complementary) are used as synonyms. In Poland an additional terminological confusion stems from the fact that we often use the phrase "voluntary insurance" in the context of private insurance, but the phrase is actually already reserved for universal health insurance in the National Health Fund, paid on a voluntary basis. We should certainly look at the mechanisms used in other countries, but any assessment in the context of the possibility of copying them must be extremely careful. An important example is Poland and our close neighbor, Slovakia. While in Poland decentralization of the National Health Fund and the introduction of competition has been regularily promised since 2007 (in the current year, 2013, a relevant draft law is to appear) in order to increase efficiency, Slovaks came to exactly the opposite conclusion, and in order to achieve the same goal, announce the nationalization of private insurers and the centralization of the system. As the recent history shows, Poland definitely prefers basing on its own experience. If in the near future the government makes the announced decentralization, it would be the third big reform of the healthcare system in 15 years (in 1999 we introduced Healthcare Funds, and in 2004 - the National Health Fund). It's hard to resist the impression of the lack of a long-term vision, which seems disturbing in the context of the inexorable demographic change. Currently, the largest experiment in the field of organizational change of the healthcare system takes place in the United States, where - to put it simply - the role of the state is being increased. The aim is to introduce a general scheme, which has been inexistent in the United States in the name of specifically conceived freedom. The main changes are to

take place in 2014, but already now we can risk stating that the opinions as to their effectiveness will be greatly divided, as in the case of assessing the merits of their introduction. Because private health insurance is always derived from the public system, it is difficult to talk about global trends in this area. This confirms the multiplicity of solutions, various types of insurance, even within one country, and differences in classification and terminology. In addition, the matter is complicated by the fact that private health insurance is characterized by features that significantly distinguish it from conventional insurance. The basis of insurance is the existence of "insurable risk." In the model, the insurance risk should be static (not subject to significant fluctuations over a longer period of time), the losses - incidental and generally beyond the control of the insured, and the risk - unpredictable for an individual person, as opposed to the risk referred to the general population. Health insurance, however, is much more complex. Risks are not static, because they change significantly over time and each of the insured will take advantage of the benefits in the long term and will do it repeatedly (high risk of moral hazard). At the same time, the insured has a kind of control over part of the risk by behavioral factors (for example – using stimulants) and technological progress makes the definition of risk still evolving. All this leads to certain unpredictability in relation to risks, assessing exposure to them, and consequently - their costs.

COUNTRY	TYPE OF INSURANCE
Austria	Complementary BBP Supplementary Substitute
Belgium	Complementary E Complementary BBP
Bulgaria	Supplementary Complementary BBP
Cyprus	Substitute
Czech Republic	Supplementary Substitute
Denmark	Supplementary Complementary BBP
Estonia	Substitute
Finland	Supplementary Complementary E
France	Complementary E Supplementary Complementary BBP
Germany	Substitute Complementary E Complementary BBP Supplementary
Greece	Supplementary
Hungary	Complementary BBP Supplementary
Iceland	Supplementary

Ireland	Supplementary Complementary E Complementary BBP
Italy	Complementary BBP Complementary E Supplementary
Latvia	Complementary E Complementary BBP Supplementary
Liechtenstein	Complementary BBP Supplementary Substitute
Lithuania	Supplementary
Luxembourg	Complementary E Complementary BBP Supplementary
Netherlands	Complementary BBP Supplementary
Malta	Supplementary
Norway	Supplementary
Poland	Supplementary
Portugal	Supplementary Complementary BBP Complementary E Substitute
Romania	Supplementary
Slovenia	Complementary E Complementary BBP Supplementary Substitute
Slovakia	Substitute
Spain	Supplementary Complementary BBP
Sweden	Supplementary Complementary E
United Kingdom	Supplementary

(E) – extra payments

(BBP) – beyond-basket provisions

Source: Thomson S, Mossialos E., Private health insurance in the European Union, LSE Health and Social Care, 2009, p. 15

Australian model. Australia as a model or example of "evidence -based healthcare"

Krzysztof Łanda MD

Anna Kordecka

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State policy seeks a balance between the participation of public and private sector in healthcare. Australian healthcare system is an example of the implementation of system solutions. Private health insurance is an important part of it.

To achieve this objective, the state encourages people to buy private health insurance, while offering basic protection in the form of the Medicare system. Most of the issues relating to private health insurance are regulated by the Act of 2007. The provisions clearly define the framework in which the private health insurance system operates, including: adjusting the scope of guaranteed medical services (guaranteed basket limited to the most important health benefits) under the basic insurance policy; a ban on the differentiation of the contribution, depending on the health risks and requiring reconciliation of the medical services and the contribution with state institutions. The expenditures of the private sector account for around one third of total health expenditure. Among the private sources of financing we must list out-of-pocket payments and private health insurance - both supplementary and complementary. In Australia, the majority of private insurance policies are bought by individuals and group policies or the ones purchased by the employer are rare. Private health insurance may cover:

- The cost of treatment in public hospitals (where the patient has the status of a private patient), and in private hospitals (in this case, there is a mixed financing of medical services: 25% of private and 75% of public ones), this also includes access to innovative treatments that are not available to patients with only Medicare - a complementary component of the private insurance; staying in a private hospital, in addition to the choice of doctor, is also associated with faster access to healthcare - it is a supplementary component of the private insurance

- Outpatient benefits (called ancillary services), non-guaranteed under the public health insurance, which mainly include medicines and medical devices remaining outside the guaranteed basket (not included in the Pharmaceutical Benefits Scheme), but optical, dental and physiotherapeutical services, plastic surgery, the benefits in the field of alternative medicine, the costs associated with the transport of patients, nursing patients at home, the cost of hearing aids - these are covered by complementary insurance.

It should be noted that insurers offer mixed, complementary and supplementary policies. Having a policy and the scope of the guaranteed benefits depends largely on the income of the individual. In some cases, the law imposes on the insurer the obligation to offer insurance that guarantees a specific range of benefits, for instance - insurer must have a policy that covers all costs associated with hospital care. One of the important elements of the Australian system of private insurance is the principle of community rating, which determines the equal insurance rate for all citizens, regardless of their health status. It should be noted that in 2000 the ability to vary the amounts of premiums based on age (lifetime cover) was introduced. The purchase of insurance (covering the costs of hospital care) before 30 years of age guarantees the stability of the contribution for a further period of insurance. Buying insurance after turning 30 years of age is associated with increase of the contribution rate by 2% each year (up to 70%). Within the initiatives aiming at supporting the development of the private sector, the government subsidizes the cost of private health insurance at the level of 30% (since 2005 funding at a higher level for older people above 65 years of age - 35%, above 70 years of age - 40%, additional funding for low-income people and people under 18 years of age). Persons who do not have private health insurance (with incomes at a sufficiently high level), however, are liable to an extra payment of 1% of taxable income. Implementation of these system solutions contributed to the increase in the number of persons with private health insurance from about 31% in December 1999 to about 43% in March 2005. The website of the Australian Government (http://www.privatehealth.gov.au) contains detailed information on the range of services covered by public and private health insurance and insurance policies available.

IN SHORT

Australian Government policy seeks to maintain a balance between the public and private sectors in healthcare. The State encourages citizens to use private healthcare by donating the insurance and also provides basic public security, covering the most important provisions. The issue of private insurance was regulated by the Act of 2007. Most policies are bought by individuals. Overall, the expenditure of the private sector (insurance and out-of-pocket expenses) accounts for about one third of total health expenditure. Private insurance is a mix of supplementary and complementary option. The amount of premiums can vary basing on age. The implementation of system solutions in Australia contributed to an increase in the number of peo

Comments

Marek Balicki MD PhD

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Private health insurance has been operating in Poland for many years. However, its scale is very limited. According to the estimates by the Polish Chamber of Insurance, this form of insurance covers 450,000 people annually and the value of the contribution is about 400 million, which represents less than 0.4% of total expenditure on health in Poland (2011). Private insurance is now offered by several insurance companies. One of the reasons for the lack of development of private insurance in Poland is a lack of specific regulations on this matter. Private health insurance operates on basis of the Law on Insurance Business, which does not contain provisions specific to healthcare. At the same time, in the last two decades in Poland we have witnessed the development of medical subscriptions market, within which medical companies offer packages of health services. Both employers and employees fund these services. They often include the provision of occupational medicine. The value of the subscriptions reaches 2-3 billion per year. It is worth noting that subscriptions are similar to private health insurance, however, they are not conducted on the basis of the Law on Insurance Business. The Ministry of Health supports rapid development of private insurance, seeing this as an opportunity to increase the overall budget for healthcare and to reduce queues to the specialist services. It would be one way to reduce the growing imbalance between the increasing demand for health services, and the ability to satisfy them. The pressure to increase spending on health is mainly related to an ageing population, development of medicine and growing expectations of citizens. According to statements made by officers of the Ministry of Health, private insurance - to fulfil the expectations - should have a mass character. The adoption of appropriate legislation and the development of private insurance will be in favor of the insurance companies.

The main argument in favor of regulation of private health insurance in the form of the law is the already mentioned lack of legislation relating to the specifics of medical services. Whatever the future scope and scale of this form of financing health services, general regulations included in the the Law on Insurance Business are insufficient and do not provide adequate protection of the interest of both the private and the public interest. For instance, this market is characterized by a significant asymmetry of information. Without certain standardization, evaluation of the differences between the products will be a very difficult task. Also taking advantage of public services by the patients with private insurance needs regulation. There is no dispute about the fact

that private health insurance should function as a complement to the public healthcare system. It is unrealistic, however, to regard PHI as a solution to the growing imbalance between revenue at the cost side of the healthcare system. In the coming years, the main focus will be set on public sources. Especially in the light of the fact, that the starting point is quite low. Public expenditure in relation to GDP is less than 5%, while the average for the EU countries (EU-27) is 6.5%. As it can be seen from the elaborate of the European Commission, "The 2012 Ageing Report", the demand for healthcare financed from public funds in Poland will grow faster than in most EU countries. The situation is not facilitated by the ongoing economic crisis and the increasingly limited opportunities of rising public spending on social protection, including healthcare. But that does not mean that in the next few years it is possible to significantly increase alternative sources of funding i.e. private funds. Current private expenditure, according to the Central Statistical Office (2011) makes up 27% of the total expenditure on healthcare. Most of them (about 82%) are direct, out-of-pocket expenditures of households, incurred at time of medical service. More than 70% of the direct costs of households account for charges for drugs and medical supplies, and further 15% - for the costs of dental services. It seems unlikely that such ranges could be successfully covered by private insurance in the near future. So in the area of interest there are left only 15% of the funds (about 3.5 billion), which are now spent on outpatient services (except dentistry). It is, however, unlikely that the majority of Poles would decide not to use the services of private medical practices under the existing rules and in a short time change behaviours established for decades. Thus, replacing the existing direct expenditure of households with a more mature form of financing medical services will not be easy. It is assumed that insurance companies will manage private funds better than the patients themselves. It should be noted that the arguments about the benefits of the replacement of out-of-pocket costs with additional security contributions and the consequent increasing the efficiency of private financing for healthcare are not so obvious. Administrative costs of private insurance are very high and sometimes exceed 20%, while the cost in general insurance can be reduced to a few percent. It appears that it would be better to redirect the flow of public funds. We also don't have large social potential for the development of private insurance. According to a recent report by Professor Czapiński - "Social Diagnosis 2013", 72% respondents answered "no" to the question of willingness to purchase private health insurance, even if it guaranteed to improve access to health services and their quality. Only less than 4% of the households are willing to pay premiums of more than 100 PLN. In case of significant development of private insurance, the problem of equal treatment regardless of the form of insurance will lay on the side of public service providers. We can not ignore legitimate concerns about the inferior treatment of patients insured only with the National Health Fund. These concerns are confirmed by studies conducted in other countries. They indicate that if the resources (staff, equipment and beds) are sufficient, there is no difference. But in the case of a shortage of resources, the patients with private insurance appear to be favorited (Germany).

The development of private insurance would require good legal and institutional frameworks, particularly in the situation of low oversight of the public payer. To sum up, I have to conclude that the dynamic development of private insurance in Poland in the coming years is unlikely. It is unrealistic to assume, that in this way we will reduce the imbalance between revenues and costs in healthcare. The latter goal will require a gradual increase of public spending, at least to the level of the European average and the introduction of non-market transparent system of rationing health care. Particular attention is required to ensure equal treatment of patients by healthcare providers, regardless of the type of insurance held, especially in the case of limited resources. Private health insurance is an important addition to the public health system. The duty of the state is to regulate this area of law.

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For many years there have been discussions on the assumptions of optimal healthcare system and the role, place and nature of insurance in it. Despite the passage of years (1st International Congress on "The role of insurance in healthcare" took place in 1999), the debate on the issues of introduction of supplementary health insurance is still lively. The health status of society has to do with the level of wealth, as well as with public spending on healthcare. At the same time, human health is considered to be the highest value (in 2011, 70% of respondents said that health was the most important value in their lives). In 2004-2009 in the Polish society the incidence of cancer, tuberculosis and mental and behavioral disorders increased. Health is the most important factor of satisfaction with the quality of life. International Health Barometer survey conducted in 2012 by Europ Assistance and Research Institute Cercle Sante shows that the Polish health system is in the worst one among all countries surveyed. An average Pole assesses it for 2.6 points (in 2011, 2.9 points, in 2009 - 2.5 points). For comparison, the Italians rated their healthcare for 3.7 points, Czechs – 4 points, Swedes - 4.7 points. French, Spanish and British admitted more than 5 points. The most satisfied are the residents of Austria, who rated their health system for 6.5 points. 41% of Poles had to give up medical care for the lack of money, 20% had to put aside a visit to a general practitioner, 17% refrained from buying drugs, and 15% - from a visit to the dentist. Every 10th Pole, due to lack of funds, gave up treatment of a serious illness, and another 10% had to put aside the purchase of glasses or contact lenses. The survey on shortages of consumption shows that 35% of Poles living in urban areas have reduced or waived private health treatment. The most serious health problems are long queues in hospitals, and on the other hand - still poorly developed system of private health insurance. The Health Barometer survey found that 90% of Poles are most afraid of even longer waiting for an appointment or treatment in the coming years. At the same time, one quarter of Poles would be willing to accept a tax increase, 30% - to agree for the development of private health insurance, and 20% - to cover part of the cost of public health from their own pockets. The economic crisis has also strongly affected the health system. Undoubtedly - organizing an efficient, satisfactory system of saving citizens' lives and health is one of the greatest challenges of the twenty-first century civilization. At the same time, the experience of other countries shows that the system of health and life protection, that is fair, effective and accepted by all at the same time, does not exist - as evidenced by results of the Health Barometer. The report of the Organization for Economic Cooperation and Development (OECD) is noteworthy in this regard. Among the report's recommendations for the Polish healthcare there is a need to reduce queues to

benefits, extend the refund in dentistry, introduce co-payments for medical services, introduce better regulations for doctors employed both in the public and private sectors There is also the need of careful construction of a system of private insurance, that wouldn't result in the exclusion of the less affluent. Almost every second Pole - according to Health Barometer - hopes that future generations will be much better. One of the areas in which life can improve, is the healthcare. Thus, it is worthy to focus on healthcare system across boundaries and take care of the greatest human value - the health. In this system private insurance is certainly needed.

Michał Pilkiewicz

The discussion on the introduction of PHI should be considered especially in the context of long-term care policy in Poland. The question is whether, in the next several years, the current healthcare system will be able to guarantee the current level of public access to medical services. It seems that in the current budgetary situation and with the prospect of inevitable demographic changes it will be difficult to balance growing needs of patients with limited financial possibilities of the healthcare system. Its main source of financing is public funds. The NHF budget has been increasing in the recent years. Despite this, the needs exceed the financial capacity of the payer. In subsequent years, the financial situation will be determined mainly by demographic factors. For this reason, on the one hand it comes to a situation where the payer's income will be limited due to reduction of the number of contributions; on the other hand we should expect rising costs associated with benefits for the growing number of patients aged 55+. In this situation, without a significant increase in the level of state funding it will not be possible to maintain the current level of services and improving access to treatment. The current level of funding for healthcare by the patient in comparison to other European countries is high. It is difficult to assume that private funding will continue to be a factor increasing access to treatment. The increase in patient expenditures may also be limited by economic factors such as wages, salaries and pension benefits. The growing problems in the financing of the health system have been discussed in the countries that have introduced private health insurance systems. Decisions of this type are strategic and long-term. Their impact can be assessed from the perspective of more than a dozen years. If we decide to implement the PHI in Poland, we can benefit from the experience of countries where such a system has existed for many years so far, so that the model implemented in Poland would not only provide increased resources across the system but also increase the efficiency of their use. Ensuring equal access to resources from PHI to all service providers operating in the market will improve patients' access to treatment and reduce the co-payment level. It seems that a properly planned and performed public discussion along with thorough educational campaign is critical to the success of PHI. An established patient awareness and expectations related to the provision of broad access to free healthcare by the state are factors that are difficult to change. However, patient education, the result of which may be a change of views, is essential to improve the healthcare system in Poland, especially for older people and future generations.

Professor Hanna Kuzińska

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In Poland, about 10% of the total domestic demand is individual public consumption. It is the publicly funded consumption, which is at the same time addressed to specific individuals. We deal with such type of consumption sending our children to school, to funded summer camps, purchasing subsidized tickets to museums and theaters, borrowing books from the public library, attending cheap art classes or taking advantage of free treatment in the clinic and hospital. Undoubtedly, the biggest part of individual public consumption falls into two sections of the national economy - health and education. The average intake of an average resident on health in 2011 was 2 791 PLN (which amounts to 107.5 billion PLN across the country), and in the field of education - 2 164 PLN (83.4 PLN). As already noted, this intake is both publicly and privately funded. An increasing proportion of healthcare financing belongs to the households. Even in 2000 we funded 33% of healthcare, and in 2011 it was already 38%. An interesting solution is to finance health subscriptions by employers in the private health sector. The percentage of households that do not pay for healthcare out of their own income or benefit from public healthcare, but with subscriptions purchased by the employer, increased from 4.9% in 2000 to 6.3 % in 2011. Assigning - on the one hand by the state, on the other hand by the households - rising nominal amounts to healthcare means a change in the pattern of consumption. If the consumption of health services in general consumption rises, expenditure on other goods - especially food, drink, clothing and footwear – decreases. The financial importance of the health sector will be growing - as evidenced by global trends. It is therefore necessary to stop the trend containing in moving more and more financial responsibility for healthcare funding on households. Experience shows that there is no alternative for financing healthcare from public funds (from tributes). We might therefore consider simplifying the billing system. Eliminate the health premium and finance the largest part of health expenditure - a network of hospitals - from the state budget, while the primary and ambulatory healthcare would be financed directly from the budgets of local governments. In particular, the study shows that the

fulfilment of the traditional functions (including healthcare) by the state requires a strong and effective public sector. Additional public financing of healthcare (much lower in Poland than in other countries) should not come from budget deficits, but the restructuring of public expenditure. For example, part of the public sector - particularly developed in Poland - should be moved to the health and social care. Another source of private funding for healthcare may be private health insurance, but it will not be very efficient, if it does not take a form of a fee for a directly named service - for example, guarantee of immediate medical advice - no later than the next day, or charge for admission to the hospital no later than within three days, or free drugs in case of illness, and so on. Otherwise, it will assume the form of a voluntary self-taxation, which is hard to gain acceptance. The popularization of PHI is supported by an illusion of paying health premiums from the salary. Probably a large proportion of employees believe that they finance healthcare from their own salaries, paying a mandatory fee of 7.75% of the base, which is shown in the annual tax return. In fact, personal income is reduced for health purpose only by 1.25 % of the base – of course, it is mandatory rather than voluntary. If this part of the premium would suddenly become voluntary, part of the insured persons could withdraw from paying, because they would see no relation between the payment and the quality of health services received.

COUNTRY	2003	2010
Bulgaria	7,84	-
Cyprus	6,75	-
Luxembourg	7,66	-
Romania	5,33	-
USA	15,61	17.55
Netherlands	9,77	11.98
France	10,93	11.61
Germany	10,92	11.51
Canada	9,78	11.38
Denmark	9,30	11.08
Austria	10,30	10.98
Switzerland	11,25	10.89
Portugal	9,73	10.72
Belgium	10,00	10.49
Spain	8,18	9.60
Sweden	9,31	9.54
Norway	10,01	9.34
Iceland	10,38	9.29
Slovenia	8,64	8.97
Finland	8,15	8.96
Slovakia	8,49	8.49
Hungary	8,57	7.83
Czech Republic	7,44	7.41
Lithuania	7,00	7.00
Poland	6,24	6.98
Estonia	4,99	6.34

Source: Eurostat (Access: 13 April 2013)

Final recommendations

The report presents different points of view, opinions and analyses on the implementation and functioning of PHI in Poland. Let's look at the most important conclusions and recommendations that emerge from this discussion. In recent times, we observe positive phenomenon of growing interest in the subject of PHI. However, while the increased activity in this area is a positive fact, the variety of presented opinions indicates the need to systematize the existing views concerning both the validity and the implementation of PHI in Poland. On the basis of the material presented, there are some important lessons to be taken into account when implementing the PHI to the Polish healthcare system. These are:

1. The need to take strategic actions aimed at improving the current situation in healthcare. These should address the problem of declining access to healthcare and poor quality of services. In the long run, the actions taken should balance the needs and capabilities of the healthcare system and meet the growing challenge of consequences of demographic changes in the society.

2. Regulate legal issues and create practical solutions to organize and support the proper and efficient operation of the system of private insurance. This, supported by analysis of the effects of regulation is essential while making decisions concerning PHI implementation.

3. The creation of a comprehensive strategy for the management of a basket of guaranteed services, tailored to the specifics of the Polish healthcare system, the needs of society as well as assumptions about the PHI. The analysis of the experiences of other countries, where PHI have already been implemented, should be helpful in that regard.

4. The need for broad-based education and information campaign, especially significant in the light of the fact that public knowledge of PHI is insufficient.

5. The need to develop a broad access to PHI for the whole of society. This means offering these services at attractive and affordable prices, which in turn will provide an additional flow of funds to the healthcare system. It is important that these measures are available for both public and private providers.

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