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TYPES OF PRIVATE FINANCING OF MEDICAL CARE BY PATIENTS IN POLAND

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Abstract

The share of privately paid medical care is steadily increasing. Polish patients pay immediately for single services and may also privately conclude the contracts for medical insurance or subscription (steady access to complex private medical care). The aim of this paper is to draw the reader's attention to the possibilities a Polish patient has of obtaining complex private medical care. The paper describes the range of services which are guaranteed for all patients insured by National Health Fund (financed from public resources) and contracts of private health insurance and medical subscription.

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Introduction

Access to medical care is one of the fundamental social and economic problems of each country. The demand for medical services is constantly growing while the availability of medical care financed with public means is becoming increasingly limited. Patients want quick access to high quality medical services, but Poland cannot afford them. In Poland the total expenses for the health care system account for as little as 6.2% of GDP, which places our country far behind such countries as Bulgaria (7.7% of GDP) or Hungary (7.8% of GDP). In countries of "old" Europe these expenses exceed 8% of GDP, while quite often they reach as much as 9-10%. The highest budget expenditure on health care in Europe is in Switzerland (11.4% of GDP), France – 11.2% of GDP and Germany – 10.7% of GDP (Report of Karolinska Institutet and Stockholm School of Economics, 2009). Currently the main source of financing the health care system in Poland is health insurance contribution. The means from the contributions paid by the insured are collected by National Health Fund, which then concludes contracts with service providers for providing health services. Other sources of financing the health care system in Poland and its service providers are: state budget, employers expenses and private expenses of the society on health care. The market of private health care is one of the fastest-developing sectors in Central and Eastern Europe, growing at the speed of 20% annually and set to continue this growth in the nearest future.

According to article 68 of the Constitution of the Republic of Poland of 1997, everybody has the right to health care, every citizen also has the right to access to medical services financed from public means, on conditions determined in the act on health insurance. Special care should be taken of children, pregnant women, disabled people and the elderly. The right to health care also covers the obligation to take up actions for the benefit of the whole

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population and the actions for the benefit of individual people. However, securing the right to health care and equal access to health care services financed from public means guaranteed in article 68 of the Constitution is not tantamount to the guarantee of obtaining all services and does not imply that they are completely free of charge. As far as the rights of a patient to health care services, the Constitution contains the reference to the act which regulates this issue in detail. Since 1st October 2004 the issue of health insurance is regulated in Poland by the Act of 27th August 2004 on Health Care Services Financed From Public Means (consolidated act: Journal of Law from 2008, number 164, position 1027 with subsequent changes) hereinafter called the "Insurance Act". The above act determines above all the principles of universal – obligatory and voluntary health insurance and conditions and range of provided health care services financed from public means as well as the principles of financing the above services. Equal access to services financed from public means, irrespective of the financial situation of a patient is realized in particular in such a way that universal health insurance is based on the principle of social solidarity. It consists in the fact that each insured person, regardless of the size of his contribution, receives the same medical care. Everybody pays an equal contribution, which, since 1st January 2007, amounts to 9% of their revenue and receives the same medical care. The growing problems of availability and quality of services financed from public means, and especially the prolonging waiting time for specialist services (ranging from a few months to even a few years) account for the increasing interest of patients and service-providers in private market of medical services. Every year Poles spend more and more of their own means on private medical care and the number of offers of complex access to commercial health services is increasing. The Ministry of Health estimates that in 2010 Poles spent on private health services around 30 billion zlotys (obtained from: www. sluzba zdrowia.prawo-w- sluzbie-zdrowia/ on 8.04. 2011). The subject of this article s to present the spheres in which Polish patients insured in National health Fund finance the health care system while they bear their private expenses (not connected with paying contributions to public insurance). The aim of the article is to present the possibilities that an individual Polish patient has to provide himself with complex access to private medical care. Private medical care in Poland is complementary to the universal system of health care. This is because at present there is no possibility of resigning from making contributions to universal health insurance.

Health services from public health insurance

At the beginning of the presentation of types of private medical care available to Poles, we should define the range of availability of medical care financed from public means. The method of financing the health care system in a given country depends on the model of health care system adopted by it (Paszkowska, 2006). The basic sources of financing health services in every country are the consequence of the model of health care system adopted by it. Generally we can differentiate 2 models of domestic health care system, namely:

1) insurance system (based on health insurance of citizens),
2) tax system (the so-called national health service).

The current health care system used in Poland is an insurance model (contributions of the insured finance most of the public medical care). This model is mainly created by the Act of 27th August 2004 on Health Care Services Financed From Public Means (consolidated act: Journal of Law from 2008, number 164, position 1027) and the law enforcement provisions

issued on its basis. However, we should not forget that there are also elements of the budget system in Poland (for example financing highly specialist services).
The National Health Fund in Poland was obliged by the law makers to organize the provision of health care services for the insured people by means of the system of contracts. The Fund does not provide the services itself, but only organizes their provision. The service-taker (patient) may obtain guaranteed service (that is financed from public means) only from the provider which signed the contract with the National Health Fund (NHF). The NHF, when concluding a contract with a particular service provider (for example with a clinic), obliges to pay this provider for the determined health services performed by the provider. The patient who has the status of an insured person in NHF comes to the public or private clinic which signed contracts with NHF may obtain the required guaranteed service which was contracted here in principle free of charge (possibly for partial payment, if regulations allow so, for example in dentistry).
The total value of NHF obligations from the contracts concluded with service providers cannot exceed the costs predicted towards this aim in the financial plan of the Fund. Two ways of normative settlement of services have been adopted:

1) annual sum per capita,
2) unit price of a settlement unit,
3) lump sum.[2]

The basic principles of universal health insurance stipulate equal treatment of citizens, social solidarity and providing the insured with equal access to medical care services as well as freedom of choice of service providers (article 65 of the Insurance Act).
The Insurance Act creates the subject scope of the right to health services from the insurance for the service user. The service user (the insured) has the right to obtain health care services, which in light of article 5 of the Insurance Act, include: health services, material health services and associated services. Health service is an action aiming at preventing, preserving, saving, restoring or improving health and other medical action resulting from the treatment processes or separate regulations determining the principles of providing them. The material health service includes such materials associated with treatment as medicines, medical products including orthopedic objects, and auxiliary materials. Associated services include accommodation and nutrition in a full-time medical center and first-aid transport services. On the basis of the Insurance Act the Polish insured citizen has the right to the so-called guaranteed services. The term 'guaranteed services' was introduced in the amendment to the Insurance Law from 25th June 2009 (Journal of Law number 118, position 989) which changed the analyzed here Act starting from 12th August 2009. According to the glossary of legal definitions included in article 5, guaranteed service is a health care service financed fully or partially from public means on the principles and in the scope defined in the Act. Due to the above regulations, we can state that the service-taker or patient has the right to obtain health care services normatively classified as guaranteed. Guaranteed services are financed from public means. These services are completely free or only partly payable by the insured. Generally service users have the right to medical care services aiming at preserving health, protecting from illnesses and injuries, early diagnosis of illnesses, treatment, nursing and preventing disability and limiting it. In article 15, section 2 of the Insurance Act, one can find

[2] Chapter 4 of the appendix to the Regulation of the Minister of Health from 06th May 2008 on general conditions of signing contracts on providing medical care services (Journal of Law from 13th May 2008).

a list of guaranteed services for the service user and financed from public means. According to the above regulation, service users have the right to guaranteed services within:

1) basic health care,
2) clinic specialist care,
3) hospital treatment,
4) psychiatric care and treatment of addictions,
5) medical rehabilitation,
6) nursery and care services within the long-term care,
7) dental treatment,
8) spa treatment,
9) provision of medical products being orthopedic objects and auxiliary means,
10) medical lifesaving services,
11) palliative and hospice care,
12) highly specialized services,
13) health programs,
14) medicines.

The catalogue of services from article 15, section 2 of the Insurance Act is a general one. The basis of qualifying a health care service as a guaranteed service is its evaluation taking into account the statutory criteria, especially such as: its effect on improvement of citizens' health, consequences of the aftermath of an illness or health condition, clinical effectiveness and safety, relation of costs to obtained health effects and financial consequences for the health care system, including the subjects obliged to finance health care from public means.[3] Classification of particular services into the group of guaranteed services is in the competencies of the Minister of Health. The Minister qualifies the services after obtaining recommendations from the Head of the Agency of Medical Technologies Evaluation, taking into account the above-mentioned criteria. The proper Minister dealing with health issues commissions the Head of the Agency to prepare recommendations for a particular health care service concerning its qualification as a guaranteed service, together with determining the level of financing (expressed by the amount of money or percentage of costs) or the ways of financing it or conditions for its implementation. The proper minister for health issues, as a result of the amendment to the Act, obtained statutory delegation to define through regulations the list of guaranteed services. On the basis of the above delegation, the Minister of Health issues in August 2009 several regulations concerning guaranteed services in particular areas (for example basic health care, hospital treatment, rehabilitation treatment, dental treatment, etc.) The regulations appeared in the Journal of Law, in numbers 139, 140 from 31st August 2009. The proper Minister for health issues may remove a given service from the list of guaranteed services or change the level or method of financing or conditions of implementing this service, acting ex officio, or following a petition, after obtaining recommendation of the Head of the Agency. Health insurance mostly finances basic health care and specialist clinic and hospital services. In view of the Insurance Act, basic health care consists in preventing, diagnostic, healing, rehabilitation and nursing health services in the area of general medicine, family medicine, provided within the clinic health care. Specialist service, on the other hand, is provision of health care in all areas of medicine, excluding the services provided in basic health care (for example ENT treatment, cardiology, orthopedics,

[3] Compare article 31a of the Act of 27th August 2005 on health care services financed from public means (Journal of Law from 2008, number 164, position 1027).

ophthalmology, surgery). Specialist services may be provided in clinics or in hospitals. Clinic health care is provision of health care services for patients who do not require to stay in hospital for the whole night.

In Poland limited access to medical care for the insured persons in NHF is connected with limiting the range of services and the waiting time for services. Health care services in hospitals and specialist services in clinic health service are provided on the first come, first served basis on the days and times of their provision. If the patient cannot be treated immediately, he or she is entered on the so-called waiting list.[4] In case the health condition of the insured person changes and this necessitates further provision of the service, the patient informs the service provider about it, and the provider, if this results from medical criteria, changes the time of providing the service and informs immediately the National Health Fund about it. NHF publishes on its website the information on the waiting lists at particular service-providers, giving the number of waiting people and the average waiting time for a particular service. The waiting lists are in practice a legal form of limiting access to guaranteed services. The waiting time for specialist clinic services may range from a few weeks up to a year, while the average is about three months. Patients wait for orthopedic and ophthalmic surgeries even 2-3 years.

As far as the health services for the insured in NHF are concerned, expenditure of private means generally takes two forms: that is when a patient pays for the service which was not classified as guaranteed, and mainly, as partial payment for some spheres of guaranteed services. Partial payment concerns mainly the so-called hotel costs of stationary services, while in dentistry and medicines, there is full payment or partial payment. The Polish insured partly pay for example for their spa treatment.[5] They must bear the costs of travel to and from the spa and also partly pay for food and accommodation in the spa center. The subject obliged to finance the health care services from public means covers the costs of food and accommodation of the insured person up to the limit defined in the contract between the province branch of NHF and the spa center. The costs of food and accommodation are defined in the regulation of the Minister of Health. The size of payment depends on the season (the more expensive season lasts from 1st May to 30th September) and the room standard (the most expensive single rooms with a bath, the cheapest – a room for many people without a bath). For example a single room in a spa, depending on the season, costs 26, 50 or 33 zlotys, while a double room with a bath costs 16 or 22 zlotys, while a room for many people 10 or 12 zlotys for each day of stay. Generally, the payment the insured person has to make is the product of days of stay and the level of financing by the service user the costs of food and accommodation in the spa for one day of stay determined in appendix number 2 of the regulation from 28th August 2009 on guaranteed services in spa treatment. Children and youth up to the age of 18, and if they are still studying – without age limit, as well as children entitled to family pension, do not cover the costs of food and accommodation in preventorium and spa sanatorium.[6] The insured person bears partial costs of their stay in a long-term care institution. A patient staying in a care and treatment institution, nursing and care institution or

[4] Compare article 20 of the Act of 27th August 2004 on Health Care Services Financed from Public Means (Journal of Law from 2008, number 164, position 1027).

[5] Compare the regulation of the Minister of Health from 28th August 2009 on guaranteed services in spa treatment (Journal of Law from 31st August 2009).

[6] Article 33 of the Act of 27th August 2004 on Health Care Services Financed from Public Means (Journal of Law from 2008, number 164, position 1027).

in an institution of health rehabilitation which provides full-time services, covers the costs of food and accommodation.[7] The monthly payment was established at the level of 250% of the lowest pension, but the payment cannot exceed 70% of the monthly income of the service user as stipulated by the regulations of social welfare.

The area in which the insured people have the highest share of their own means is dentistry. A patient has the right to health services of a dentist and to dental materials used in providing these services, classified as guaranteed ones. Moreover, children and youth up to the age of 18 and pregnant women and women in period of confinement have the right to additional health services provided by a dentist and to dental materials used in providing these services, classified as guaranteed services for these people.[8] The scope of dental services available within the system of financing services from public means has been limited practically from the beginning of Patients' Funds through determining the list of guaranteed services. The updated list of guaranteed services in dentistry is given in the regulation of the Minister of Health from 30th August 2009 on guaranteed services in dental treatment (Journal of Law, number 261, position 2601, with subsequent changes). The current list of guaranteed services has not changed significantly in comparison with the previously valid one, defined in the regulation of the Minister of Health from 24th November 2004 on guaranteed services provided by dentists and dental materials as well as on the documents confirming the right to these services (Journal of Law, number 261, position 2061 with subsequent changes). NHF pays for the basic dental materials, while the patient pays for the above-the-standard materials. The novelty is the elimination of the time limit in replacing dentures, which means unlimited services in this area.

Medicines and medical products defined in lists issued on the basis of the Insurance Act by the Minister of Health are guaranteed services. The medicines generally available for the service users are: basic medicines, prescription medicines, supplementary medicines. Basic, prescription and supplementary medicines are handed out to the service user on the basis of prescription, at the following payment forms:

1) lump payment – for basic and prescription medicines made of normatively determined pharmaceutical raw materials or from ready medicines from the list of basic and supplementary medicines, on condition that the prescribed dose of the prescription drug is smaller than the smallest dose of a ready drug in solid form applied orally,
2) in the amount of 30% or 50% of the drug price – for supplementary drugs.[9]

The lump payment and partial payment concern a single packet of the medicine defined on the list. Service users who have infectious or psychic diseases or are mentally disabled, as well as those who have chronic, inborn or developed, illnesses drugs and medical products are prescribed free of charge, for lump payment or for partial payment. The current (March 2011) list of basic and supplementary drugs is determined by the regulation of the Minister of Health from 22nd December 2010 on the list of basic and supplementary drugs and the amount of payment for supplementary drugs (Journal of Law, 29th December 2010).

[7] Article 18 of the Act of 27th August 2004 on Health Care Services Financed from Public Means (Journal of Law from 2008, number 164, position 1027).
[8] Article 31 of the Act of 27th August 2004 on Health Care Services Financed from Public Means (Journal of Law from 2008, number 164, position 1027).
[9] Compare article 36 of the Act of 27th August 2004 on Health Care Services Financed from Public Means (Journal of Law from 2008, number 164, position 1027).

Universal (public) health insurance covers the most of the Polish society, however, interest in private medical care has been growing steadily for the past few years. Due to limited availability and steadily declining quality of health services financed from public means, private medical care is becoming a real alternative. A common feature of the Polish reality is purchasing single health services on the private market (for example consultations with doctors, diagnostic tests). This is connected, on one hand, with quicker availability of the service, and on the other hand with the opportunity to choose the service provider. Apart from spending private means for immediate health care, the Polish patient may be provided with private medical care which is complex and long-term, bearing only the lump costs of using the health services. The patient may also gain access to additional private health care signing a contract of individual health insurance with the insurer or on the basis of the contract of providing health services (the so-called medical subscription) concluded directly with the service provider operating on the market of medical services. The essence of private medical care in the above formats lies in providing the patient with quick and de-formalized (for example without requests) access to health services determined in the concluded contract (for example specialist consultations, diagnostic tests).

Individual private health insurance

One of the forms of managing the risk of illness is insurance. A private health/ medical insurance policy is one of two forms in which a patient may secure private medical care for himself. Not a long time ago the Polish market of insurance products connected with medical care was modest and generally contained the following products:

1) insurance of the costs of treatment for travelers abroad,
2) daily insurance of hospital services,
3) insurance against developing a particular illness (covering the payment of compensation).

The condition of public health care and increasing affluence of the society and its insurance awareness account for the dynamic development of the private insurance sector in Poland. More and more insurance companies have been offering various products belonging to the so-called health/ medical insurance group. We have not still developed uniform terminological instruments for the above insurance types. In practice three terms are used, namely sickness insurance, medical insurance and health insurance. The author considers the term health insurance as the most adequate one for the analysis of the product. Health insurance should be understood as insurance against the risks of expenses connected with the necessity of using health services (Stachura, 2004). Private health insurance is still regarded as novelty on the Polish market. Not a long time ago, a client could only insure against possible stay in hospital or against the risk of contracting some serious diseases, whereas at present they can obtain complex medical care in various variations within private voluntary health insurance they contracted. Voluntary health insurance is defined as non-obligatory insurance chosen and paid for by individuals or through employers, which calculate the premium on the basis of health risk (Frąckiewicz-Wronka, 2006). It is possible to differentiate the following types of private health insurance with reference to their scope:

1) substitution-parallel and competitive to public insurance,
2) complementary – guarantee services not covered in universal insurance,
3) supplementary – guarantee quicker and wider package of services (Holly, 2004).

In practice private health insurance is on one hand an alternative for people who are not obligatorily covered by public insurance in National Health Fund. On the other hand, they are complementary and parallel for the people covered by universal health care.

Voluntary private health insurance exists in two forms – individual and group ones. The development of private health insurance on the Polish market started with group insurance. Following increased interest of employers in providing private medical care for their workers, insurance companies introduced a new product – group health insurance. Currently the offer of insurance companies contains the product of individual health insurance providing access to medical care in Poland. Depending on the offer, the basket of guaranteed services is extremely varied and usually narrower than the one available in universal health insurance. However, the offer has the benefit of quick access to medical services (for example within 48 hours an appointment with a specialist doctor).

Health insurance is offered as a product of the insurance activity of specialized entities. The insurance activity consists in offering and providing protection against the risk of some random incident. A random incident is the one which does not depend of the will of the insuring person and is uncertain to appear in future (for example illness), while its effect is damage to personal or property good. Insurance is generally divided into property and personal one. The requirement for running personal and property insurance activities are determined mainly in the Act of 22nd May 2003 on Insurance Activity (Journal of Law, number 124, position 1151 with subsequent changes). Private health insurance may be offered in Poland only by insurance companies or mutual insurance societies. According to the Insurance Act the insurance company may function in form of a joint stock company. The offer of an insurance company is purely commercial while the products of mutual insurance societies have social aims (they protect the members of the society against unexpected costs of medical treatment). The insurance company provides insurance protection on the basis of insurance contract concluded with the insuring person. The basis for covering a patient (client) with private health insurance is concluding an insurance contract with a chosen insurer. In the insurance relation we have in principle three entities: that is the insurer, the insuring person and the insured person. The insurer is the entity (insurance company) which takes the risk of certain consequences defined in the contract in case the insurance event happens. The insuring person is an entity which concludes the insurance contract with the insurer. The insured person is the entity whose well-being (health, life) was covered by the insurance contract. The insured person in health insurance may only be an individual person. With individual insurance the insuring person and the insured person are often the same individual. In case of individual insurance it is sometimes possible to cover also children and spouse with the insurance protection. The circle of potential insured people is limited for formal criteria which must be met by these people. The biggest limitation to the access to the offer is the age of the potential insured person (on the day the insurance becomes valid), which cannot usually be higher than 60-65 years. It is also possible to establish the lowest limit of the age in which we are covered by the insurance (it is usually 18 years). Apart from the age, the health condition is a criterion limiting the conclusion of the insurance contract (it concerns the absence of particular illnesses or particular period of time that must pass after treating them). The insurance company may require that the insured person or the person for the benefit of who the insurance contract is concluded, was subjected to medical check-up or

diagnostic tests with minimum risk, with the exception of genetic examination, in order to assess insurance risk, determine the right to the benefit and the amount of this benefit.[10]

The contract of individual health insurance is currently voluntary. The contract of insurance is regulated in the Civil Code (articles 805-834). The Civil Code provides general norms for the contract of insurance, due to the development of various kinds of insurance, which require application of many specialist solutions. It is a contract on the basis of which the insurer, within the scope of its company activities, obliges himself to perform a defined service in case the incident described in the contract happens, while the insuring person obliges himself to pay the premium. The basic performances of the parties of the insurance relationship include:

1) financial performance of the insuring person, in form of payment of the insurance premium,
2) financial performance of the insurance company in form of payment of agreed compensation or performance.

For example, if the insured person falls ill and requires specialist consultation, the costs of this consultation will be covered by the insurer. The value of the premiums is established by the insurance company after evaluation of the insurance risk. Insurance premium should be determined according to the criteria presented in general conditions of insurance, especially concerning the value of decreases or increases of base sums. The premium is calculated for the whole period of the insurer's liability. If the parties did not arrange otherwise, the premium should be paid at the moment of concluding the insurance contract, and when the contract was made before the insurance documents were delivered – within fourteen days from their delivery.

The insurance contract is a nominate contract, and belongs to the category of contracts which are mutually binding and remunerative. According to article 809 § 2 of the Civil Code, the contract of insurance should be confirmed by the insurance company with the insurance policy. The policy is a document written by the insurer on an appropriate form, containing essential provisions of the concluded contract of insurance. The policy should be a document containing such content which clearly determines who is insured, by whom, and in what scope. The insurance contract is usually concluded for the period of one insurance year. According to article 812 § 1 of the Civil Code, before concluding the contract of insurance, the insurance company is obliged to submit the insuring person the text of general terms and conditions of insurance. General terms and conditions of insurance (GTCI) are the terms and conditions determined by the insurance company on which the company accepts the risk declared by the client. GTCI contain descriptions of situations in which the insurance company may not pay out the compensation or may lower it. GTCI also list situations in which the insurance company does not bear any liability for the damage. GTCI also determine the obligations of the insured person and the consequences of not following them (for example an obligation to inform the insurance company of the illnesses passed, etc.).

As far as the subject of the voluntary health insurance is concerned, it is connected with the health condition of the client and his or her demand for health services. It boils down mainly to financial protection against the risk connected with illness. The contract of complex health insurance guarantees access to defined health services. The definition of health services appropriate for the whole sphere of law can be found in the Act of 30th August 1991 on health care centers. According to article 3 of the above act, health service is an activity aiming at

[10] Article 21 of the Act of 22nd May 2003 on Insurance Activity.

preserving, saving, restoring and improving health and other medical activities resulting from the treatment process or from separate regulations defining the principles of their application (especially connected with doctor's examination and consultation, treatment, medical rehabilitation, diagnostic tests, nursing of the sick, palliative and hospice care). Further specification of the scope of insurance is always done through pointing at specific guaranteed services. The feature of the analyzed insurance product is its optional character, as within the offer of one insurer the product is available in several options (for example: basic, extended). As far as the method of realization of the insurance company obligations is concerned, it is mostly in form of direct access to health services performed in medical centers cooperating with the insurer. The principle used in nearly all private health insurances is unlimited access to basic health care. The element which differentiates the scope of insurance between the options and between the insurers is availability of specialists and diagnostic tests. The differentiation mostly concerns the number of available doctors' specialties (from a few to more than ten) and the number of diagnostic procedures. An innovative element is access to hospital services.

Private insurance policies are honored mostly by such service providers as health care centers. A private patient usually uses non-public health care centers which signed a contract with his or her insurer, however, it is also possible to use the services of independent public health care centers, as the law permits it. The Act of 24th August 2007 on Changing the Act on Health Care Services Financed from Public Means and other Acts (Journal of Law number 166, position 1172) introduced to the Act on Health Care Centers additional source of financing paid health services provided by independent public health centers, namely from the means of insurance companies on the basis of concluded contracts of insurance (article 54, section 2b of the Insurance Act). As a result, the above regulations allows for paid treatment of people who have private insurance policies in these centers.

The development of private health insurance in Europe has always been shadowed by public systems and is less supported by once common tax privileges (some countries abolished them, for example Sweden and Spain, others limited them, for example Germany). The share of private means in financing the health system in particular countries of "old" Europe ranges from 10% to 14% (it concerns the countries of the insurance model). The highest percentage of citizens with private insurance policies can be found in Germany, France and the Netherlands. The union market has several types of voluntary insurance. For example, in Great Britain there are supplementary insurance policies, while in France they have complementary and supplementary ones. In Poland patients do not have any tax reliefs for possessing private insurance, although it would be recommended to introduce such solutions to support the development of such policies at least for a couple of years. Poland remains one of the poorest countries of the EU. For the development of commercial health insurance it is not only the average level of income that counts, but also the distribution of income in the society. Therefore currently, the insurance companies offer may be addressed at relatively small percentage of population and the situation will not change in the nearest future. Typical users of private insurance in Poland are inhabitants of large cities with above-the-average income. In 2009 Poles bought 400 thousand health insurance policies. The analysis carried out by Expander in 2009 shows that health policies differed in price, scope of provided services and the number of centers available for the insured people. In case of offers for single people the package price depends on the sex of the insured person. In most insurance companies women pay more for their insurance.

Individual medical subscriptions

The Polish market of services offered by medical service providers, following the model developed in other European countries, was expanded in late 1990s with a new complex service in the area of private health services. The fundamental problem is how to call the analyzed service. Due to the lack of legal norms, court rulings and specialist literature on the above subject, we can only use the names used by the entities which offer the subject service. Of many names functioning on the market and closely related to the name of the service providers (for example Enel-Care) or to the type of services (for example Medical Care X), the dominant phrase is that of medical package or medical subscription. The medical subscription term seems the most appropriate one, as it adequately reflects the type of the analyzed product of the medical service provider. No regulation brings the definition of medical subscription. Generally subscription means the paid right to use a particular service, usually pre-paid by the customer for a specific period of time. In case of future medical services, it is difficult to predict and therefore to calculate the quantity and type of services to be used by the patient. It is possible that the patient will not use any services. It should be assumed that the so-called medical subscription is a specific service offered by serviced providers on the medical services market (especially by health care centers), whose subject is connected with providing health services to patients covered by the service in exchange for the periodic payment of a determined size which is of lump type (Paszkowska, 2007). Depending on the addressee, we can differentiate, just like in case of insurance, two types of medical subscriptions: namely for employees and for individual patients (clients). Private medical subscriptions were recently a dynamically developing segment of medical market. The biggest private medical networks (Medicover, Lux Med, Medycyna Rodzinna, CM LIM) had in total 690 thousand patients who were offered medical subscriptions (Piłat, 2008). The past 2-3 years have witnessed a lot of resignations from subscriptions among service providers or leaving only corporate subscriptions (for employees). For example, Centrum Medyczne Damiana prepared various packages for corporations. It does not have any subscriptions for individual clients, however, the company recommend taking out the Vision insurance with the Inter Polska company. Formally Medicover, once the forerunner and leader of the Polish subscription market, also does not have subscriptions for individual clients. Medicover proposes alternative purchase of medical insurance at its related company, namely Medicover Försäkrings AB.

The essence of the subscription medical care is undoubtedly, to provide an entitled patient quick access (in terms of time and formalities) to the services of appropriate quality determined in the contract (for example specialist consultations, diagnostic tests). The scope of medical care covers mainly ambulatory health services in basic and specialist medical care. The availability, quality and broad range of health services offered in the subscription is to identify and eliminate early health problems. The legal basis for providing health services within the medical subscription is a civil contract made between contracting parties. The contract of provision of medical services or medical subscription is not regulated by the rules of the Civil Code (nor by any other rules). This is the so-called innominate contract. It has undoubtedly civil nature, and the possibility of contracting it results from the fundamental principle of freedom to make contracts. According to article 353^1 of the Civil Code the contracting parties may regulate their legal relationship as they wish, as long as its content is

not against the properties (the nature) of a relationship, any act or principles of conduct in community. As a result of the above principle:

1) there is freedom to conclude or not to conclude the contract,
2) there is a possibility of free choice of service provider,
3) the content of the contract may be freely shaped by the parties,
4) the form of the contract also in principle depends on the will of the parties.

The patient may but does not have to conclude the contract and has total freedom of choosing a service provider. The content and form of the contract of performing medical care depends only on the will of the parties. As the law makers did not define the subject and content elements of the contract, the parties enjoy great freedom as far as the shaping of the contract is concerned. However, the content of the contract cannot be in contradiction to the law (especially to acts regulating the rights of the patient, the performance of medical professions and the functioning of medical care centers), it cannot aim at circumventing the act (for example for tax reasons) or be contradictory to the principles of conduct in the community. Concerning the principles of performing the contractual obligations and the consequences of non-performing, especially contractual liability, appropriate regulations of the third book of the Civil Code may be directly applied.

The subject of the medical subscription contract is provision of health services in the prior determined scope, that is providing the entitled persons with access to private medical care. The scope of health services being the subject of the contract depends on the will of contracting parties. It should be precisely defined in the content of the contract or in the attachment to it and cover the types of services (list of available examinations, specialist consultations, etc) and possible limitations in access to them (especially limits, requests to specialists and to tests). Of vital importance for the patients and typical for subscription health care it is to determine the maximum waiting time for the services (especially to specialist doctors and doctors of basic health care) in the contract. As far as the basic health care is concerned, it is practically assumed that the patient should be seen by the doctor on the day of registration and not later than within 24 hours. Longer waiting time, such as 48 hours concern visits to specialists. However, defining the terms in the contract does not exclude the possibility of using the services on the registration day. The scope of offered services is closely related to the price of the subscription. Service providers usually have some (mostly between 3 and 5) options of services (from the basic, cheapest ones, covering only a narrow range of services to very wide and most expensive ones). The offered services mostly include:

1) basic health care,
2) specialist health care (ambulatory),
3) medical diagnostics,
4) prevention programs.

The biggest differences in particular areas concern the access to specialist treatment (for example most packages do not cover rehabilitation and, above all, dentistry) or the scope of available diagnostic tests (excluding more expensive procedures, such as magnetic resonance or tomography or limiting them). It should be noted that hospital treatment and first aid transport are very rarely offered. There are usually three types of subscription: basic, typical (medium) and extended (extra) one. Particular service providers call them using names connected with different colors of the client's card (silver, gold) or range of services (Basic, Plus, Comfort). The services of the basic subscription include: basic medical care, specialist ambulatory health care (but limited so that, for example, it does not cover the right to access

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all kinds of specialists), diagnostic tests (usually only the basic type) and health prevention programs. The typical subscription, just like the basic type, covers basic health care and specialist care as well as diagnostic tests, but of a wider scope (for example access to all or most possible specialists, more specialist tests). The extended offer covers the full range of tests, including specialist ones, such as tomography or magnetic resonance, access to all specialists, and sometimes also to dental services.

In a relationship of obligation which was created as a result of concluding a contract on providing medical care, there are two types of subjects, namely the parties which concluded the contract and the subjects for the benefit of which the contract is concluded. One party of the contract on medical subscription will always be the service provider, that is the subject providing medical services. The service provider may be the subject entitled to provision of medical services and possessing medical subscriptions in his offer. The subscription offer is typical for large cities (it is especially popular in Warsaw, Poznań, Krakow and Katowice). In practice the parties of the subscription contract will be health care centers, mostly non-public ones. Subscriptions are offered by large health care centers which have doctors-specialists in most or all areas of medicine and well-developed diagnostic facilities. Medical packages are characterized by the limited scope of use, as patients may use only the services of one center (or the network) and possibly from the services offered by service providers cooperating with the offer maker. However, we can observe an increasingly popular phenomenon of cooperation between medical service providers from various cities in order to perform the tasks resulting from the subscription contract (subcontractors) so that the client could have medical care in various cities. Apart from the service provider, the second party of the contract is the subject which purchases the package of medical services for himself or for the benefit of third parties. Depending on the subscription the second party of the contract will be an employer (subscription for workers) or a patient (individual subscription). With individual subscriptions an entitled person is pointed directly in the content of the contract and is usually the party of the contract (unless we are dealing with services for third parties). It is possible, at additional fee, to cover members of the subscription holder's family with medical care. Family members are usually a spouse and minor children.

The subscription contract may be concluded for a definite period of time (mostly it is one year) or for indefinite time. In the contract of medical subscription, apart from defining the subject and object scope of it, we should determine the subscription fee. Subscription fee is an established amount of money that the employer is obliged to pay to a particular service provider in set periods of time. The fee is a lump and periodical payment (it is paid in defined periods of time). Subscription fee is usually paid monthly, but it may be paid at a different frequency (quarterly or annually). Subscription prices are extremely varied and depend mainly on the offered scope of services and range from around 100 to 300 zlotys per month (though one could also find subscriptions costing 500-600 zlotys). In practice, the prices of subscriptions are higher than the prices of health insurance policies.

Currently we can observe movement of both service providers and clients away from individual subscriptions to insurance contracts, which are not only cheaper but also offer wider access to services (especially in the subject and geographic scope).

Conclusions

The costs of health services all over the world are growing much faster that the budgets of the states, therefore most countries face the necessity of changing their present health policies. These trends are global and seem irreversible. Increased costs of medical care due to development of medical technologies forces the EU countries to initiate various saving economizing activities (such as limiting services) and leads to the development of commercial health insurance. In 2011 NHF has 56 billion zlotys at its disposal, which is nearly twice the amount it had five years ago. However, statistically since 2006 the private health sector has witnessed an increase of over 50% and will reach the level of 30 billion zlotys this year. In 2009, Poles mostly spent their own money on medical equipment and drugs (60%), rehabilitation services (20%) and such products as health insurance or medical subscription (obtained from: www.ubezpieczenie-zdrowotne.com.pl/ on 11.04.2011).

Theoretically each insured person in Poland has the right to equal, wide access to medical care financed from public means. Under the laws, each insured person has the right to medical care financed from public means in form of the so-called guaranteed services. In practice, patients wait several months to visit a specialist doctor or even a few years for an operation. As the past few years have shown, the money from NHF is enough only for the first half of the year to pay the hospitals and clinics. After holidays, patients have lower chances for specialist treatment in a given year. A typical phenomenon are ever longer queues for services. In almost every health system the organization of the process of providing health services is connected with limited access to this care. Usually, this aim is achieved through the use of the so-called waiting lists and the use of the catalogue of guaranteed services. Both methods are currently used by the Polish law maker, therefore the insured person has the right to only guaranteed services and their availability is connected with the waiting time.

Until 2005 there had not been any private health insurance offering a complex package of medical services in Poland. At present, private insurance against costs of treatment are slowly becoming more popular and more available. Such product can be found in the offer of the following companies: Allianz, AXA, Compensa, InterRisk, PZU. As far as private health insurance is concerned, unfavorable phenomenon is the so-called “risk selection” (also known as taking the best bits). It means that the insurer selects such risk which he expects will have lower costs of service than the amount of collected premiums. In practice it boils down to limiting the access to insurance offer for the people with high health risk. Unfortunately, a person with health problems generates high costs of medical treatment and as a result becomes “persona non grata” for the insurer.

The aim of the insurance contract and the subscription contract is the same – to provide access to private health services for lump payment. The subject of both contracts is similar (medical care/providing health services), however the legal nature is different. The advantage of health insurance, which also constitutes a difference between insurance and subscription, is direct statutory regulation of the product and specific supervision of it (Polish Financial Supervision Authority). In case of insurance policies a patient may use not only one center but several of them. In case of a subscription patients have at their disposal one center or network. Service providers offering subscriptions are usually operating in large cities, therefore inhabitants of smaller towns are recommended to conclude insurance contracts. In case of insurance policies a patient has more freedom to choose the center providing services and such a solution is cheaper. Subscription fee does not depend on age and health condition of a patient. It is quite different in insurance companies (age and health condition do influence the amount of

premium). Moreover, insurers usually use the so-called period of grace, that is the possibility of using some medical services (usually the most expensive ones) only after a certain period of time since the beginning of insurance In case of subscriptions there is no grace period – which means that the patient may use all services from the very beginning of the contract – this is one of the essential advantages of subscriptions over insurance. The basic differences between the insurance policy and the medical subscription are shown in table 1 below.

Table 1: Comparison of health insurance and medical subscription

LEGAL FORMS	CONTRACT OF HEALTH INSURANCE	CONTRACT OF MEDICAL SUBSCRIPTION
SERVICE PROVIDERS	multitude of service providers (in numbers and places – many cities) patients have a greater choice	Single or network service providers, geographical limitations (only one or a few cities)
SCOPE OF SERVICES	Wide – ambulatory services (doctor's consultations, diagnostics) additionally hospital treatment, various options of services	Wide – ambulatory services (doctor's consultations, diagnostics) various options of services
PRICE (monthly)	Lower (from around 50 zlotys), differentiated (criteria of age, sex, health condition influence the size of the premium)	Higher (from around 100 zlotys) lump sum (regardless of sex, age or health condition)
LIMITATIONS	Usually examination/statement concerning health condition are required and there is a grace period (no right to use the services), age and health condition influence the possibility of concluding a contract	No obligation to undergo examination, no grace period or own share in costs

Source: Own elaboration on the basis of market offers

There is no doubt that the expenditure on health protection in Poland is too low. On the other hand, it is undisputable that the health requirements of the society are always higher than the possibility of financing them by the state. In practice only people with private insurance policies/health packages may count on quick access to health services. Private health insurance provides patients with wide and relatively cheap insurance cover in return for the payment of the established premium. The government also wants to have influence on the health insurance market in Poland. In March 2011, Minister Ewa Kopacz presented the main guidelines for the project of the act on additional health insurance (currently the project was passed on to social and inter-ministerial consultations). The project defines the conditions and rules of taking out additional health insurance and running the activity in this area. Additional insurance will be offered only to the people who are interested in it and who can afford it.

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