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## Article

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# Financing health care and the development prospects of private health insurance in Poland

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**Abstract:** Polish legislation names the general health insurance system as the main source of health care funding. Public health care funding in Poland is relatively small compared with other European countries, which restricts population's access to medical services and exposes the health care system to constant criticism (the Euro Health Consumer Index, 2017). The rising demand for health care and medical services, driven by demographic and technological factors as well as by changing expectations towards the services standard, is another reason why a search for alternative sources of health care funding seems inevitable. It is viewed that one of the solutions that might facilitate the functioning of the Polish health care system is private health insurance that could become a major element of national health care policy and provide the health care system with extra funding. The article presents some aspects of health care funding in Poland that are likely to increase interest in private health insurance and outlines the level of development of this insurance sub-market using the selected statistics (the number of insured persons, gross written premiums). The article has been prepared based on data provided by the Central Statistical Office, the Polish Insurance Association and Eurostat.

**Keywords:** health care, funding, private health insurance

**JEL codes:** I13, I18

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## 1. Introduction

The main goal of EU's sustainable development strategy is to reduce social and economic inequalities among the Member States. One of the strategy's key instruments is public health policy (Mazur-Wierzbicka, 2017: 54), which aims to ensure high standard of population health

believed to be one of the prerequisites to sustainable development and a measure of internal cohesion and social balance (WHO, 2002: 3; Pettigrew et al., 2015: 2119).

In the majority of European countries health care is mainly funded through the general taxation system (Beveridge's system) or compulsory social insurance (Bismarck's system). However, advances in medical technology and demographic pressures make it increasingly clear that public health care expenditures fall short of consumers' needs, which brings more and more attention to the potential role of private money in financing health care.

Polish legislation points to general health insurance as the main source of health care funding. Public health care spending in Poland is relatively low (i.e. compared with other European countries), which makes medical services less available and exposes the health care system to unwavering criticism (Euro Health Consumer Index, 2017: 32). With the demographic and technological factors and expectations of better health care quality increasing demand for health care services, a search for alternative sources of health care funding becomes inevitable (Polish Insurance Association, Ernst & Young, 2013: 6-9).

Private health insurance is thought to have the potential for becoming a major instrument of national health policy and for increasing the efficiency of the Polish health care system as an additional source of funding. By extending the range of treatment opportunities, cutting waiting times and increasing competition among health care providers it can also help tackle the problem of limited access to the public health care system.

The role of private health insurance in Poland in the context of demographic changes has already been examined by authors such as Jeziorska (2016) and Laskowska (2017). This article is aimed to present some selected aspects of financing health care<sup>1</sup> in Poland, which have the potential for attracting more interest to private health care insurance products. Based on statistical data (the number of insured persons, gross written premium, etc.) sourced from the Central Statistical Office, Eurostat and the Polish Insurance Association, it also outlines the present state and development prospects of the health insurance market.

## **2. Public and private expenditures on health care in Poland – an outline**

The Polish model of health care is inseparable from health insurance (Piechota, 2014: 207). The rules governing its functioning are laid out in the Act on Publicly Funded Health care

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<sup>1</sup> According to CBOS surveys, interest in private medical services is increasing mainly because of public providers' problems with meeting consumers' health needs (CBOS, 2016: 3).

## FINANCING HEALTH CARE AND THE DEVELOPMENT PROSPECTS OF PRIVATE HEALTH INSURANCE IN POLAND

Benefits of 27 Aug. 2004<sup>2</sup> and the Act on Medical Activity of 15 April 2011. The main source of health care funding is mandatory health insurance premiums paid on behalf of the National Health Fund (NFZ), an institution financing and contracting general and specialist medical services with public and non-public providers (ambulatory and stationary care). Only some dentistry services are reimbursed, and over-the-counter drugs and occupational medicine services are not refunded at all (Paszowska, 2008: 8).

Another major source of health care funding is the state budget, which finances specialist medical procedures, health care policy programmes, emergency medical services, the public blood service, the activities of the public health authority, as well as paying health insurance premiums for persons who cannot afford them for the lack of income. Health care-related investment projects are financed by local governments that also manage, supervise and control them.

The Polish public health insurance system includes almost all of the population (ca. 98%) and nominally entitles consumers to use a wide range of medical services for no payment other than the premiums they pay. At the same time, though, private health expenditures, consisting mainly of households' out-of-pocket payments and amounts expended by health insurance funds, employers and charities are greater in Poland in relation to total health than in most EU member states.<sup>3</sup> The structure of health care funding (according to the National Health Account) in the years of analysis is shown in table 1.<sup>4</sup>

**Table 1. Public and private health care expenditures in selected years according to the National Health Accounts**

Specification	2008	2013	2014	2015
Current expenditure on health care (PLN million)	83438	105635	107458	114142
Total current public expenditure (PLN million)	60214	74639	75929	79887
Premium-based compulsory health insurance	53809	64106	65912	69334

<sup>2</sup> Ustawa z dnia 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych, Available at: <http://prawo.sejm.gov.pl/isap.nsf/download.xsp/WDU20042102135/U/D20042135Lj.pdf>. Accessed: 2 January 2018

<sup>3</sup> See the Map 1.

<sup>4</sup> Data on health care structured according to the National Health Account methodology have been published by Central Statistical Office since 2008.

schemes (PLN million)				
Premium-based compulsory health insurance schemes in relation to the total health expenditures (%)	0.89	0.86	0.87	0.87
Current public health expenditures as % of the total current health expenditures (%)	0.72	0.71	0.71	0.70
Current private health expenditures (PLN million)	23224	30996	31529	34256
Current private health expenditure as % of the total current health expenditures (%)	0.28	0.29	0.29	0.30
Households' out-of -pocket payments	20025	24978	24850	26534
Households' out-of -pocket payments as % of private health expenditures (%)	0.84	0.81	0.79	0.77

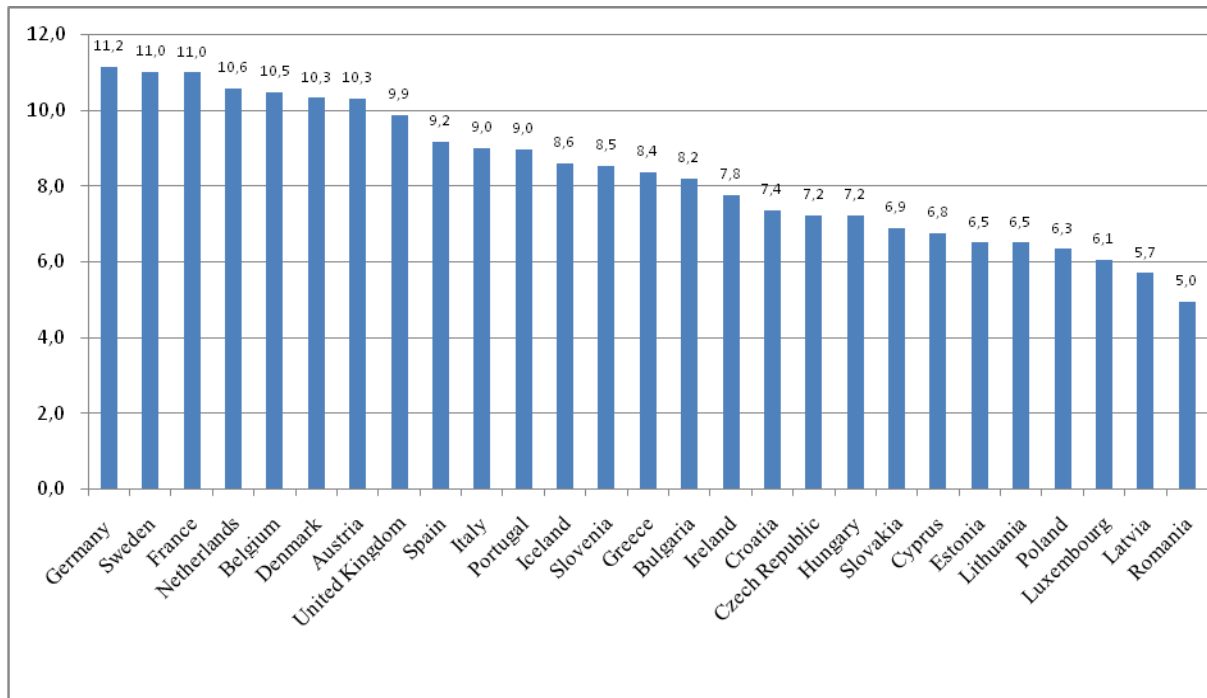
Source: created by the author, based on the data provided by National Health Accounts (Central Statistical Office, 2008, 2013-2015).

Public funds and private funds account for around 70% and 30% of health care spending, respectively. In 2015, compulsory health insurance financed 87% of the public health spending and almost 60% of the total health spending. As far as private health expenditures are concerned, in the same year households' out-of- pocket payments accounted for 77% of the private health spending (slightly less than in 2008 and 2014). The substantial amount of private health expenditures is mainly due to consumers' co-payments for reimbursable drugs and the non-reimbursable costs of over-the-counter drugs, para-pharmaceuticals and medical services offered by private clinics, which are sought for the limited availability and rather low quality of public medical services (Poland. Health system review, Golinowska (ed.), 2012: 105-106). Households' out of pocket-payments necessitated by their members' health needs frequently place a serious strain on household budgets (Social Diagnosis 2015, Czapiński, Panek (eds.): 121-123).

### **3. Health care expenditures in Poland and in other EU countries**

Poland has a long history of one of the lowest health care expenditures in the EU. According to the Eurostat data, they are much lower than in most European countries also in relation to GDP (Figure 1).

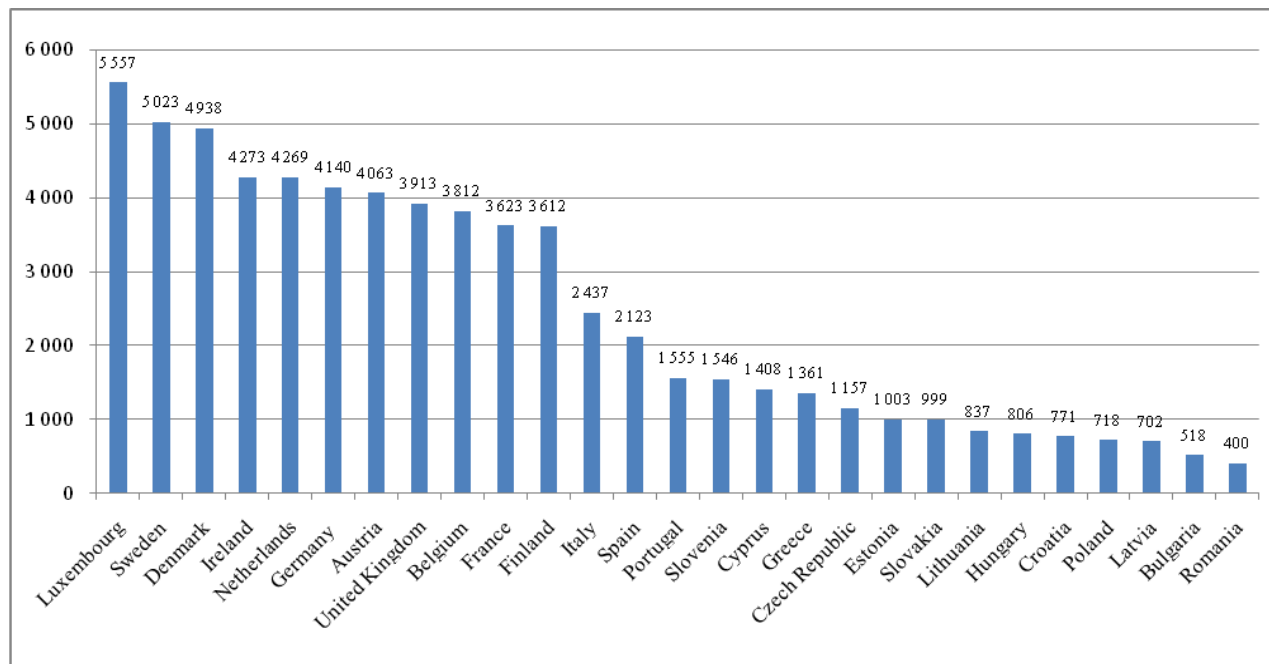
**Figure 1. Current health expenditures as a share of GDP in EU Member States<sup>5</sup> (2015)**



Source: developed by the author, based on the data provided by Eurostat. Available at: <http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do>. Accessed 14 February 2018.

In 2015, Poland spent 6.34% of its GDP on health care. The only countries where the rate was lower are Romania, Luxembourg and Latvia. Polish health care expenditures per inhabitant were also comparatively low (Figure 2).

<sup>5</sup> Data concerning Malta are not available. The Slovenian data are from 2014.

**Figure 2. Health care expenditure per inhabitant (€; PPP; 2015)**

Source: developed by the author, based on the data provided by Eurostat. Available at:

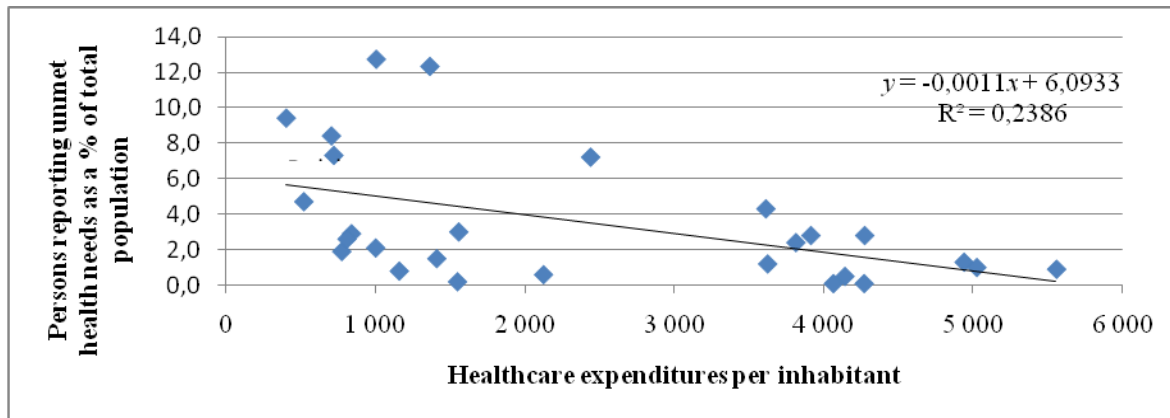
<http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do>. Accessed 14 February 2018.

In 2015, Poland's total per capita spending on health care was €718 (according to PPP), which dramatically contrasts with €5556 in Luxembourg, €4966 in Sweden and €4876 in Denmark. In EU-27, only Bulgaria, Croatia and Romania spent less than Poland.

For the consumers' health needs funding must be not only adequate, but also efficiently used. In Figure 3, the per capita health care expenditures in the EU countries in relation to the percentages of persons unable to meet their need for medical examination for financial (too expensive) and geographical (too far) reasons and because of long waiting times are plotted as a linear regression function.<sup>6</sup>

<sup>6</sup>  $y$  denotes the percentage of persons reporting unmet health needs and  $x$  is health care expenditures per inhabitant.

**Figure 3. Health care expenditures per inhabitant (€; PPP) and the percentage of persons reporting unmet needs for medical examination because of the health care system related reasons (2015)**



Source: created by the author, based on the data provided by EU-SILC. Available at: [http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth\\_silc\\_08&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_08&lang=en). Accessed 14 February 2018.

The regression analysis leads to the conclusion that the percentage of persons with unmet health care needs tends to be smaller in countries that spend more on health care.<sup>7</sup> Table 2 shows countries where the percentage of low- and high-income persons unable to meet their health care needs is higher than the EU average.

<sup>7</sup> Linear regression coefficient statistically significant at  $p=0.009728$ .



**Table 2. Countries where the percentage of persons with unmet health care needs exceeds the EU average, 2015**

<b>Country</b>	<b>High Income Quintile</b>	<b>Total population</b>	<b>Low Income Quintile</b>
Estonia	11.3	12.7	16.1
Greece	4.0	12.3	18.3
Latvia	2.4	8.4	17.1
<b>Poland</b>	<b>4.3</b>	<b>7.3</b>	<b>10.8</b>
Italy	1.5	7.2	15.5
Bulgaria	1.9	4.7	11.7
Finland	2.4	4.3	5.6
<b>EU-27*</b>	<b>1.5</b>	<b>3.3</b>	<b>6.4</b>

\*without Malta

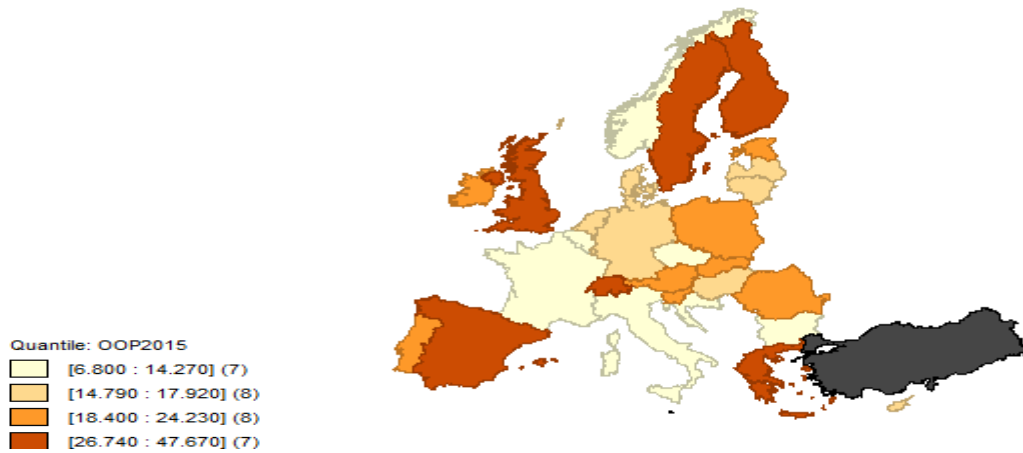
Source: created by the author, based on the data provided by EU-SILC. Available at:

[http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth\\_silc\\_08&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_08&lang=en). Accessed 20 February 2018.

In Poland, the percentage of such persons is considerably above the EU average (7.3% and 3.3%, respectively). The only countries performing worse than Poland are Latvia, Estonia, and Greece. Interestingly, however, in Poland the difference between the lowest- and highest-income persons with unmet health care needs is smaller than in many European countries.

The high rate of Polish consumers reporting that their health care needs are not met is accompanied by substantial private health care expenditures, mainly households' out-of-pocket-payments that belong to the highest in Europe.

**Map 1. Households' out-of-pocket payments as a share of total health care expenditures  
(2015)**



Source: created by the author, based on the data provided by Eurostat. Available at:  
<http://ec.europa.eu/eurostat/web/health/health-care/data/database>. Accessed 20 February 2018.

The structure of private health expenditures could be changed if the mandatory insurance system were supported by a wider use of private health insurance, because payments from insurance companies would then replace households' out-of-pocket payments. Insufficient funding of public health care, a significant share of private health care funding, a high percentage of people with unmet health care needs (including high-income persons) and consumers' expectations of better quality care point to a high growth potential of private health insurance in Poland.

#### **4. The current state and development prospects of the health insurance market**

Voluntary health coverage is purchased and paid for by individuals or their employers (Paszowska, 2008) in order to avoid ahead of time the financial consequences of likely health impairment events (insurance premiums accumulate into a fund that is available for covering the costs of temporary or permanent disability) and to distribute the protection costs among a larger number of entities (the insured) (Polish Insurance Association, Ernst and Young, 2013: 14). The insurer's liability for paying the costs of treatment is set in proportion to the agreed premium. The unquestionable advantage of private health care insurance is that it allows persons who can afford the premiums to receive specialist consultation and treatment, or to be hospitalized without having to wait for their turn. However, the private health insurance sector may also discriminate

the low-income persons, thus increasing social inequalities in access to health care (Sobczak, 2006: 83).

Private health insurance, which has a relatively short history in Poland, is a form of supplementary voluntary health insurance acquired by consumers who want to improve their access to health care services guaranteed by public health insurance. The range of health care services available from private health insurance is much narrower compared with public health insurance, but their quality is much higher.

In Poland, health insurance can be acquired as individual or group coverage and may have the form of medical subscriptions to private clinics (mostly funded by public and private employers) (Sobczak, 2006), or health policies distributed by insurance companies established under the Act on insurance activity of 22 May 2003. Both products offer similar coverage.

Private health insurance in Poland started to develop with group insurance, but now insurance companies increasingly design products meeting the needs of individual consumers. Because of their legal construction, medical subscriptions have become a very popular product. Some of them cover specific health risks or give the insured persons better access to general medical care. There are also policies that offer compensation in cash for surgical treatment in private hospitals or each day of hospitalization, or reimburse the costs of medical treatment or drugs (Paszkowska, 2008).

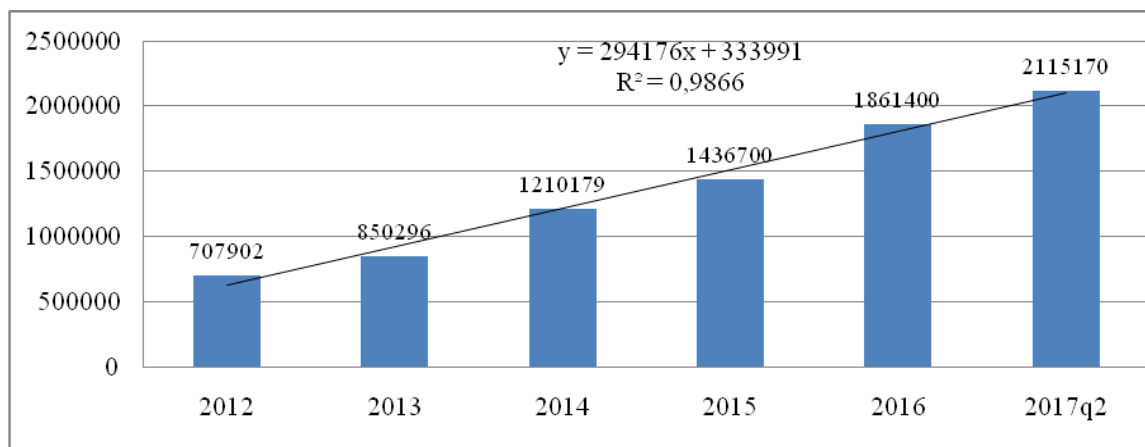
The CBOS survey of 2016 found 23% of respondents to have voluntary health insurance - 16% paid premiums themselves or the payer was a family member, for 6% premiums were paid by the employer, and 1% shared the cost of premium with the employer (CBOS, 2016: 7-8).

Although still narrow, in recent years the sub-market for voluntary health insurance has been expanding at a much faster rate than other segments of the private health care market, despite the fact that some insurance companies do not have health insurance on offer. The Polish Insurance Association (PIA) data point to a steadily rising number of persons covered by health insurance, a valid measure of the expansion of the health insurance market. In Figure 4, the change in the number of insured persons between 2012 and 2017 (first two quarters) is shown. It is noteworthy that the linear coefficient of the trend function<sup>8</sup> (Figure 4) is statistically significant ( $p=0,0006$ ).

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<sup>8</sup>  $y$  is the number of insured persons and  $x$  is time.

**Figure 4. The number of insured persons between 2012 and 2017q2**



Source: developed by the author, based on the data provided by the Polish Insurance Association. Available at: [www.piu.org.pl](http://www.piu.org.pl). 15 February 2018.

As can be seen, in the sampled years the number of persons with health insurance coverage was growing at a steady average rate of 294 176 persons a year, exceeding 200 000 in the second quarter of 2017. Most of those persons were covered by group insurance, but from 2016 to 2017 the increase in individual policies exceeded that in group policies (Table 3).

**Table 3. The number of persons with group and individual coverage**

Period	No. of policy holders		Market share	
	Individual coverage	Group coverage	Individual coverage	Group coverage
2016 Q2	314 210	1 359 505	19%	81%
2017 Q2	495 788	1 619 382	23%	77%
Change (year-on-year)	58%	19%	4 p.p. (↑)	4.p.p (↓)

Source: created by the author, based on the data provided by the Polish Insurance Association. Available at: [www.piu.org.pl](http://www.piu.org.pl). 15 February 2018.

Notwithstanding the fact that the number of individual policyholders (58% year-on-year) grows much faster than the number of persons with group coverage (19% year-on-year), the latter still represent the bulk of the market (77%).

Another relevant measure of the expansion of private health insurance is gross written premium. Its values for individual and group insurance are shown in Table 4.

**Table 4. Gross written premium**

Period	Gross written premium [PLN]		Market share	
	Individual coverage	Group coverage	Individual coverage	Group coverage
2016 Q2	37 407 382	226 145 586	14%	86%
2017 Q2	41 162 204	276 021 267	13%	87%
Change (year-on- year)	10%	22%	1.p.p. (↓)	1 p.p. (↑)

Source: created by the author, based on the data provided by the Polish Insurance Association.  
Available at: [www.piu.org.pl](http://www.piu.org.pl). 15 February 2018.

The data in Table 4 show that group insurance continues to dominate in the market for private health insurance (87%). The increase in gross written premium for group insurance was faster than in the case of individual insurance, because group insurance involves more affordable premiums than people are willing to pay for individual coverage. The most recent *Social Diagnosis* report of 2015 revealed that as much as 23.6% of households considering the acquisition of voluntary health insurance would pay premiums of up to PLN 100 per month, whereas only 4.7% would accept premiums above that level. The main determinants of consumers' interest in voluntary health insurance is household's wealth and the level of education (Social Diagnosis 2015, Czapiński, Panek (eds.): 123-124). The aforementioned CBOS survey of 2016 also found that most individual policyholders had tertiary education (41%), lived in households with per capita income above PLN 2000 (39%) and were aged 24-44 years (CBOS, 2016: 7-8).

Other factors that make people view health insurance as an interesting option is health awareness and insurance awareness. The analysis has shown that private insurance products attract more and more interest, despite the lack of appropriate legal regulations. Whether, and how, the potential of commercial insurance will be exploited largely depends on the insurers themselves, their ability to accurately define Polish consumers' needs and design products they can afford.

## 5. Conclusions

The rather modest public expenditures on health care in Poland (per capita and as a share of GDP), rather low odds that their amount will increase enough in coming years to improve the situation of health care, the substantial proportion and structure of private funds financing health care (ca. 30% are households' out-of-pocket payments straining their budgets) and a high percentage of persons who cannot meet their health needs create a climate conducive to the development of commercial health insurance industry.

The above overview of selected factors supporting the development of the health insurance market and of trends in private health insurance points to the rising importance of commercial health insurance in Poland. In addition to the analysed factors, also the gaps in the existing legislation that excludes some health care benefits from public insurance coverage drive the expansion of private health insurance (Sobczak, 2006: 82). The main law regulating the voluntary health insurance market – the insurance activity act – is general in its scope and seems to overlook the distinctive characteristics of the health care sector in Poland. All this calls for changes to the present legislation that could ensure further development of social insurance.

Although the voluntary health insurance sub-market is still narrow, this dynamically growing segment of the insurance market is certainly worth paying more attention to. Future research efforts should seek to determine how voluntary health care insurance improves access to medical services and improves the efficiency of the public health care system.

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### ***Finansowanie ochrony zdrowia a potencjał rozwoju prywatnych ubezpieczeń zdrowotnych w Polsce***

#### ***Streszczenie***

Rynek usług medycznych w Polsce w świetle prawa jest finansowany głównie ze środków z powszechnego ubezpieczenia zdrowotnego. Relatywnie niskie w odniesieniu do innych krajów europejskich publiczne nakłady na ochronę zdrowia skutkują utrudnionym dostępem do świadczeń medycznych, co znajduje odzwierciedlenie w utrzymujących się negatywnych ocenach systemu ochrony zdrowia (the Euro Health Consumer Index, 2017). Rosnący popyt na świadczenia zdrowotne spowodowany czynnikami demograficznymi, technologicznymi oraz zmieniającymi się oczekiwaniami związanymi z poziomem opieki zdrowotnej, rodzą konieczność poszukiwania alternatywnych źródeł ich finansowania. Jeden z potencjalnych czynników sprzyjających usprawnieniu funkcjonowania systemu ochrony zdrowia a zarazem istotny element polityki zdrowotnej w Polsce, stanowić mogą prywatne ubezpieczenie zdrowotne, stwarzające możliwość wzbogacenia systemu o nowe fundusze. Przedmiotem niniejszego artykułu są rozważania na temat wybranych aspektów finansowania ochrony zdrowia w Polsce mogących stymulować wzrost zainteresowania ofertą prywatnych ubezpieczeń zdrowotnych oraz przedstawienie obecnego stanu rozwoju tego segmentu rynku ubezpieczeń na podstawie wybranych charakterystyk (liczba ubezpieczonych, składka przypisana brutto). W artykule wykorzystano dane statystyczne Głównego Urzędu Statystycznego, Polskiej Izby Ubezpieczeń, Eurostatu.

***Słowa kluczowe:*** ochrona zdrowia, finansowanie, prywatne ubezpieczenia zdrowotne