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HEALTH INSURANCE – FURTHER STEP TOWARDS SYSTEM CHANGES IN THE HEALTH CARE

The most important problems concerning the implementation of the health insurance system in Poland are discussed. Main emphasis is stressed regarding the extent of realization of particular tasks as related to the capabilities of present and future health care institutions.

1. INTRODUCTION

The free and common availability of health care services, as guaranteed for Polish citizens by the Constitution of 1952, has been for the whole post-war period recognized as a fundamental feature of the health care system. Only the crisis of public finances at the end of the 1980s and the early 1990s revealed the vital macroeconomic problems which influenced the expenditure of funds for health care and, consequently, the shape of the national budget. The huge Polish debt has led to financial insolvency and forced the initiation of negotiations with foreign creditors. This foreign debt had also an indisputable influence on the health care budget. In consequence, a rapid degeneration of medical equipment in health care institutions took place, as low per capita expenditures for this purpose made its reproduction impossible. The only way to stop the process of medical services decline seems to be the reform of the existing system. This reform is taking place based on solutions adopted by the Common Health Insurance Act (Dziennik Ustaw 1998). Having a number of shortcomings, this Act however makes a system framework for any reformatory activities in this field.

2. ACCOMPLISHING PURPOSES OF THE COMMON HEALTH INSURANCE ACT

Basing on this act a program (*Informacja* ... 1997) to develop the system changes in the health care has been prepared. The set of appropriate actions can be grouped into four basic categories.

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The first one is to change the essential range of services offered by the public health care institutions. The greatest role is attributed here to the family doctor and the basic health service, being the only "entrance" into the system. The restructuring of the hospital base by adjusting it and its offer to the real demand seems also very important. The most important goal is however to stress illness prevention and health promotion (according to the rule "it's better to prevent than to treat"), as well as to adjust the activity of public health institutions to the current needs (restructuring of wards, creation of alternative forms of residential care), so patients can get adequate treatment close to their homes.

The second set of problems is expressed as a tendency to change organizational and financial forms of health care, in the way expressed by the rule "money follows the patient". This means the abandonment of financing material and labour costs in favour of financing services offered to patients, with the income of a particular institution directly related to the effects of its activity. Here, the actions include the contracting out of health services and creation of independent public institutions of health care.

The third range of activities are the tools to monitor and manage the health care system. The two most important tasks here are Medical Services Register and information systems for hospitals.

The fourth set of issues is to change the way of gaining public funds for health care, to introduce health insurance aimed at the transition to the budget-insurance model of financing health care.

The Common Health Insurance Act is coming into force in 1999. So there is little time to be properly prepared for functioning in this new system. An efficient introduction of new rules requires extra investments into new, appropriate equipment and the proper preparation of medical staff. The Act initiates changes but does not perform them. It is good however, that it has been passed, otherwise the beginning of reforms might be postponed for a long time.

The fourth set of issues has already been prepared and now is in the implementation stage, though it is subject to a number of objections (evidence for the imperfections of the Act could be the fact that already in May a team has been appointed to make necessary corrections). The realization of the other three sets of issues is not so much advanced.

In the first set, the work to form an appropriate organization of the whole system is still in progress, with the main accent on preventive actions, being the least expensive. It is also a very important task for the managers of health care institutions, who have to set cost levels.

The second set of issues concentrates on preparatory work to transform the whole medical staff (which will be a long-term process), to make them acquainted with principles of contracts and methods of entering, and also

aims at conforming the health care institutions to work in the new economic conditions – as independent institutions.

The realization of all these stages should result in the formation of a domestic market of medical services. This market, supervised by the State through the National Health Program and financed mainly by the health insurance system, would offer services by the best specialists under relevant contracts.

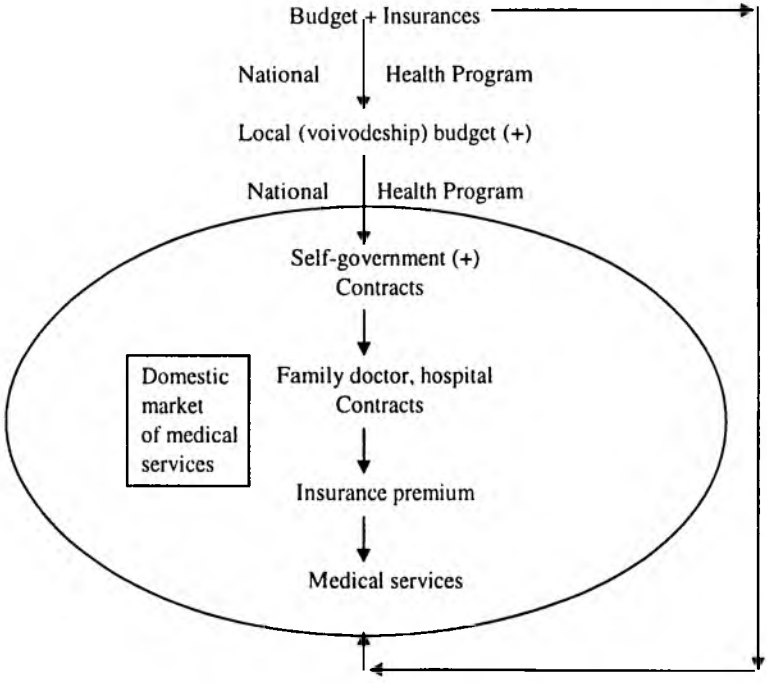

Fig. 1. Suggested scheme of fund flow for health care
Source: Ministry of Health.

3. FINANCING MEDICAL BENEFITS IN THE NEW HEALTH CARE SYSTEM

It is assumed that in the new system the financing of health care will have a budget-insurance character. The position of a budget system is precisely defined. Budget funds will be spent on basic services, additional training of medical staff, aid in larger investments or actions undertaken in the case of an epidemic threat. These funds should be stated as in the

amount, depending on current needs and capacities of the budget. So the majority of health care expenses would be transferred to the health fund, financed by collected fees. It is easy therefore to foresee that all expenses having a preventive character would be of marginal importance for these funds, as investing in prevention would be investing against themselves, investing to make people not apply for services. A distinct antinomy appears. On the other hand, the costs of prevention and those of a series of specialized treatments are incommensurable. The weakness of the proposed solution is also the lack of good cost effectiveness, ensuring the financial equilibrium of funds.

The insurance part of the system is the collection of fees to health funds, coming from all potential patients, as defined by the Common Health Insurance Act (Dziennik Ustaw 1998). However, the question of the "insurance character" of the system should be raised, as the fee amount depends on the income level of the insured and not on the evaluation of costs and risks undertaken by the insurer. The actuarial calculus, successfully applied in the field of business insurance, is lacking here. Such confinement in defining the fee amount is probably due to the lack of a reliable estimation of means spent on health care and the difficult evaluation of risk level. Of course, it is possible and probably it would be worthwhile to form systems with differentiated fees, but then the base for such a fee should be on one hand the actuarial evaluation of the risk connected with an insurance for a particular person, while on the other hand the scope of services offered against this paid fee.

The system being implemented is also not sufficiently protected against the increase of insurance premiums. The calculations already performed by various investigators show the insufficient amount of means for the current operation of future health care institutions. Only in the initial phase will the State Budget be involved into the transformation of the system. The cost of continuing reforms has to be covered by the funds themselves. Without any increase of insurance premiums it seems basically impossible. We surely cannot forget about the hitherto existing increasing debts of health care posts, the consequence of which has been the procedure of debt trading. There has not been created any efficient barriers holding back such activities.

Also quite important are the difficulties in defining the requested standard of health services. Should it copy the well functioning systems, or establish a level according to our possibilities? What would be then the attitude of patients towards the proposed reforms (the level of services offered in other countries is commonly known, though often exaggerated)? An average Polish citizen would like to have: social security like in

Sweden, medical services like in Germany, the access to newest technologies like rich people in the United States (Tymowska 1996), all this with the country's economic level and expenditures for health care much below the European average.

While trying to evaluate the quality of medical services, the Ministry of Health prepares the medical treatment schemes for particular disease syndromes. Listing what actions should be done however, makes only one part of treatment, while the other is how they should be done, and this is difficult to explicitly define. To each action listed in the register of the Ministry some score value is attributed, and to each value corresponds in turn some defined amount of money. This score should lead to a more precise evaluation of arising costs. Till now it is one of the few elements which in the future should prevent the increase of expenditure and costs.

4. THE PROBLEM OF THE DEBTS OF HEALTH CARE UNITS

The transformation process based on the Common Health Insurance Act assumes, as a primary condition, the clearing the debts and reconstruction of capitalized fixed assets of health institutions, using the budget and self-government funds. Though every year the funds are transferred to clear the debts, the question concerning the scope and cost of reconstruction remains unanswered. For example, the majority of internal health care institutions (hospitals) is exploited much below their capacity, which in the future might force either to close them or to change their specialization to some other, more needed in the region (as a minimum the coefficient of saturation of 60% is assumed, while in many institutions if reaches only 50%).

Together with the transformation of institutions the restructuring of their debts proceeds. It is difficult to imagine starting a business in this very difficult sector with frequently huge debts. The trials to cancel them in 1994 and 1995 gave no expected results. The mistake then was the flow of funds without simultaneous mechanisms preventing the uncontrolled increase of debt. The restructuring of debt is till now applied only to the institutions, for which the founding organ is the Voivode and the transformation has started in 1997.

As soon as the institution is registered, the founding organ repurchases all obligations done by budget units. At the same time, it undersigns the restructuring agreement with independent institutions.

The agreement defines the conditions and indices concerning the obligations which the institution should have been reached by 1998. The

necessary condition is that the level of due obligations does not exceed in the transition period the 5% level of the institution's budget, and in the long term ensures both lack of debts and good financial liquidity, making the activity possible. As a guarantee of fulfilling the agreement the founding organ issues 3 bills *"in blanco"* drawn at the independent institution. In the bill agreement it is stated under which circumstances the bills can be filled in and redeemed. The maximum sum up to which the institution can be again debited, once the bill agreement (compensating the debt) has not been fulfilled, equals to the actually liquidated debt. Till the end of 1998 the bills remain in the possession of the funding organ. If the conditions of agreement are fulfilled, the unfilled bills will be returned to the institutions.

The method of calculating the restructuring tranches permits payment of the debt as due on 31/12/1996 (plus interest which arose until the extinction of the debt). The debt created after this date cannot undergo the restructuring process. All funds for debt compensation are not transferred to the institution, since it is the funding organ who buys the debt.

Also, the distribution of the medical personnel needs rationalization (in some towns one medical doctor in a hospital serves in average only 7 patients, while in others doctors are lacking). So a preliminary proposal of medical personnel allocation has been prepared, causing outraged reactions, due to the postulated huge and obligatory changes in this matter.

Now in Poland there are 1,149 specialized family doctors, and including those who have an equivalent specialization the number of practitioners able to undertake duties in the new system comes to over 2000. It makes however only 12% of all medical doctors working in basic health care. This number is expected to increase to 25% starting from 1997, since 12 regional Education Centres are functioning next to the Medical Universities and Postgraduate Education Medical Centre.

The services of family doctors will be offered mainly in independent health care institutions. Independent institution is the name given by Polish law to define the form of financial management of public health care institutions. Till the end of 1991 public health care institutions could do their financial economy based only on the budget law (Dziennik Ustaw 1992; 1994; 1995; 1996; 1997). Though an evolution of this law took place, their autonomy was limited. There were no motivations for more efficient resource utilization or taking into account the efficiency indices while granting funds. Therefore independent institutions, having already these instruments, seem to have a chance for real financial management.

5. THE PROCESS OF UNIT TRANSFORMATION

The decisions concerning the transformation of existing units into independent institutions are taken by the funding organs. The voivodes present a preliminary ranking list of units to be transformed (most often those having best ratios of total debt or current liquidity) together with their obligations and estimated costs of restructuring activities (Monitor Polski 1995). The allocation of funds from the earmarked reserves for these tasks takes place based on the so-called map of needs. The choice of units to be transformed depends above all on their preparation level and the region, i.e. the demonstration of expected good financial performance or the possibility of obtaining additional financing sources.

To obtain any means for the realization of its statutory tasks, a newly registered health care institution has to prepare an appropriate offer and tender for a contract. This is a public contract by tender to offer health services in basic range, announced in the newspapers. The need of announcement is contained in the decree and is very important, though information is very specialized. Public money is given at someone's disposal, nonetheless this tender is not subject to the law of public contracts (according to juridical opinion). The tender results in the choice of the best offer of services. Afterwards, a civil law agreement for the delivery of health services in the basic range is signed and appropriate funds are transferred. These agreements are called contracts.

The strategic goal of making contracts (Tymowska 1996) is the realization of a basic rule of health care system reform – the separation of the payer (controlling the funds) from the executor of medical services. It is assumed that contracts, by reinforcing the general sector, will suppress the uncontrolled flow of patients to higher reference levels, as they could obtain the same services at a lower level and at a lower cost. The difference could be used to improve the quality of services. Though the contracted services are delivered in independent institutions (private practices), patients do not pay for them, since the fee is paid in their name by the public organ in the framework of the contract. At the same time the organization of services is transferred to the private sector, what releases the public sector from the tasks not necessarily attributed to it. Investing into the health care sector can start from other than budgetary funds.

The decisions concerning the functioning of future institution are undertaken by the management of the present units. The future institution is not obliged to keep the old structure, it may for example buy some services

from separate firms, which in some cases could lead to a lower cost of a service. The possible organizational forms will be identical to those in economic activity. The only difference is that the units being transformed obtain „in advance" the legal status. Independent institutions formed as a result of transformation can therefore take the form of various companies. In practice it is most often the limited liability company.

The process of preparing and conducting the changes is applied now to about 600 health care units. In the paper I used the former Wrocław voivodeship as an example. The most advanced transformations take place at the:

- Health Care Complex in Jelcz-Laskowice,
- Regional Centre of Labour Medicine in Wrocław,
- Regional Hospital-Sanatorium Complex for Lung Diseases in Oborniki Śląskie,
- Lower Silesian Centre for Medical Diagnostics DOLMED (this Centre obtained the status of an independent institution in July 1997).

6. CONCLUSION

The aim of this process of adjusting the health care system to function in new conditions is to improve the availability and quality of medical services. It requires the introduction of market mechanisms, rationalizing the use of public resources, and the formation of a market for medical services which would be capable of responding to patients' needs. This process of transformation however needs substantial work and costs to ensure the continuous functioning of the system and providing medical services. Unfortunately, the most important element for decision makers is the profit generated by health care institutions (which relieves the State budget) and not the basic aim for which they are created – improvement and maintaining the health of society. Similar objections are often raised by practising doctors: "there is no time for treatment, we should earn money". The passage of the Common Health Insurance Act forced the necessary system changes to begin. Are they good or bad? Today we do not know yet. The final effects of the undertaken action can only be evaluated in a few years' time. The only consolation is the fact that nearly all countries, including rich ones, encounter problems concerning the efficient functioning of the health care sector which results from the specific features of this sector.

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