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# **EU-China Social Security Reform Co-operation Project**

## **for The People's Republic of China**

### ***VOLUNTARY HEALTH INSURANCE REFORM POLAND***

*Comparison to Supplementary Health Insurance China 2008*

*“Voluntary Health Insurance as a 2nd Pillar System in Poland b  
2008”*

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## **Background and Reform in Poland since 1997**

Until 1999 the healthcare system in Poland was based on Semaszko's soviet model. In the dynamically developing market economy it became ever more obvious that the public had no real control over the central financing and management of healthcare, which resulted in the rapid development of the so called **grey zone**. Growing social dissatisfaction with the poor healthcare system manifested itself in the ever more frequent strikes by nurses and doctors who complained of low salaries and worsening work conditions. In these circumstances, in 1997 – shortly before the parliamentary elections – the government drafted an Act on the common health insurance. The Act put forward significant changes, among others it introduced health insurance which was to replace a healthcare system financed from the state budget. Following the parliamentary elections in the fall 1997 the government changed and as a result the implementation of the Act was withheld and the Act itself was amended and adjusted among others to the changing territorial division of Poland.

The reform was based on creating 16 regional Health Funds plus one additional Fund for uniformed services. The Funds financed healthcare from the resources of the insured. The resources of Health Funds were composed of income tax revenues (7%) and contributions from various institutions and individual contribution payers, obliged to pay employees' premiums for healthcare.

The first year of the reform was particularly difficult for the Health Funds when they faced the reality of financial constraints they were under. Despite the fact that the reform failed to solve the problems of the Polish healthcare system, it introduced some positive aspects which contributed to the development of a **network of private healthcare institutions**. The provider received the right to create networks and develop their own health care basket which could be contracted by the population. The population and as well the employers accepted the offer of the network providers and paying a fixed premium to those kind of providers. Nether the less the contract is private based and the services are supervised by the Ministry of Health.

The authors of the reform intended to improve access to healthcare and increase its quality, as well as reduce debts of public healthcare institutions. However, even in the first quarter of 1999, patients started complaining about the fact that access to services was difficult and the lack of information about where and by whom their illnesses should be treated. On the other hand, medical institutions complained about lack of funds and limits to the patients they could treat, and the Health Funds reported irregular and insufficient healthcare insurance contributions.

Public opinion polls were negative about the healthcare sector reform. According to one of the national daily newspapers, more than 70% of the people polled evaluated the reform negatively. This strengthened the feeling of insecurity within the Polish society. Another reform of the healthcare system was developed by the former Minister of Health, Mariusz Łapiński, which was introduced in 2003. It liquidated the regional Health Funds and created a centralized National Health Fund with 16 regional branches in the Districts (so called Voivodships).

The changes introduced in 2003 failed to improve the situation in public healthcare. On the contrary – some free market changes which improved the situation until 2002 were stopped, such as competition between the regional health funds.

### **Situation in 2005**

In the year 2005 the government announced the return of the budgetary healthcare system. Prof. Zbigniew Religa was appointed as Minister of Health and he developed a civic bill in 2005 aimed at introducing numerous free market solutions to the healthcare system. His proposals were largely based on competition between **4-6 National Health Funds, the introduction of private alternative insurance arrangements and the possibility of supplementary insurance.**

Currently the Ministry of Health is slowly working on changes to the system, but their introduction is uncertain. The proposals of the Minister of Health Prof. Religa aim at changing the healthcare system within seven years are as follows:

Developing a minimum basket of guaranteed benefits by the end of the first quarter of 2007 and by the end of 2007 the basket will undergo social consultation and pass the legislative path.

- **By the end of 2007 – establishing a network of Public Hospitals which will not be privatized.**
- **2008 (after developing the basket) – introduction of voluntary additional insurance;**
- **From 2008 or 2009 – introduction of voluntary alternative insurance;**
- **From 2008 or 2009 – introduction of voluntary nursing insurance;**
- **2009 or 2010 – transforming the National Health Fund into independent public health insurance;**

The Reform is still under the discussion in the Polish government and the parliament. However, the government in Poland changed and the new leading party might change or modify the health care reform.

The current health insurance contribution is 8.75% of gross personal income and it is to increase to 9% next year. The majority of experts and relevant political parties support the introduction of additional health insurance arrangements.

The Minister of Finance, Zyta Gilowska, proposed changes to the catalogue of expenses which are not tax deductible in her document called: "The main assumptions for the repair of the tax system". Expenses for private medical services will be calculated as a tax deductible cost and included in the Personal Income Tax statement.

### **Reform: Introduction of the Voluntary Medical Insurance as a 2<sup>nd</sup> Pillar of Medical Insurance System**

The first idea of some kind of additional private health care insurance was formulated in a Law from 1998 but the article 4a which stipulated the introduction of such additional insurance before 2002 had been taken off from the text of the law. At that moment the political atmosphere did not permit solutions potentially resulting in inequalities in the health care system (some policy makers recalled such arguments) and, just like the planned introduction of competition between sickness funds by allowing the creation of new, private funds, such solutions were never brought into life.

**Nowadays there is data proving that more than 2 million Poles pay for medical services in the private market.** Documents of the Ministry of Health underline that each year Poles spend 17 billion PLN (4,3 billion Euro) for health care services, including under-the-table payments. More than half a million people have already bought **vouchers** from private medical companies. The private insurance market still develops and it is very likely to happen that also more and more employers will buy vouchers for employees in the future. Private insurance for hospital treatment have also appeared lastly. However, they are not accessible for the majority of population due to extremely high premiums (even 600 PLN - 150 Euro - this equals the amount of the minimum monthly retirement pension for 2006).

The introduction of additional private health care insurance has been part of the MoH priorities defined in August 2006. Realization has been planned for January 1, 2008 - the day the Law on Additional Health Insurance enters into force. The idea bases on the creation of the second pillar of the insurance system. The objective of the policy is to secure access to higher standard services (that are not included in the elaborated health services basket, e.g. hospital "hotel" services). Additional insurance for such services is expected to limit the "gray sphere" and consequently to improve the functioning of the health care system. Competition between health care providers is also expected to increase because insurance companies that offer the additional package can choose with which provider they will contract.

**The main objective** of the introduction of voluntary health insurance and of the planned changes is to increase financial recourses in the public/private funded health insurance and health care system. This objective is based on the following assumption:

In case 20% of Poles would purchase the additional package, the health care budget would increase by 5 billion PLN – 1.25 billion Euros.

The MoH Poland states that the planned change in health insurance would limit the "gray sphere" and, in this way, improve the functioning of the health care system and limit corruption.

Because the health insurance companies that are responsible for the additional health insurance package can choose the provider that is supposed to provide the respective services, it is expected that competition will grow and – as a result – the quality of offered services will also increase and reduce the Out-of-Pocket payments.

Until now, no such model of voluntary health insurance existed in Polish law. If introduced, the introduction would have to be done together with a fundamental reform of the health insurance system. In the current version of the draft law the MoH proposes the following reorganisation of the health insurance system:

1. Pillar I – The participation to the NHF is obligatory and comprises all insured population in Poland. The obligatory contribution rate is set up by 9% of the monthly gross wages and guarantees a common and general access to health care services that are contracted by the NHF.
2. Pillar II – The voluntary health insurance is supplanting the Pillar I as a non-obligatory insurance. The additional premium for this insurance has to be paid to NHF by private companies collecting the fees from the patient. The draft law set up the premiums for this insurance by 32 PLN (8 Euro) which improve the access to the same health care services contracted by the NHF, but to higher standards (rooms, food or other non-covered

services, etc.).

3. Pillar III – The private organized supplementary health insurance is non-obligatory having a usual high monthly premium and provides access to health services that are not covered by NHF (excluded from the NHF insurance – the negative listed services defined by law). The private health insurance schemes have the possibility to “jump over” the waiting lists in hospitals or other services.

Pillar II is based on the following systemic assumptions:

- Guaranteed access to health care services that are contracted by the NHF;
- The hospitals will receive an additional 30% of financial recourses in case of treatment of a person insured under pillar II;
- Hospitals will not be allowed to contract more than 50% of higher standard services (there will be no possibility for the hospitals to treat 100% of additionally insured patients);
- Every insured person will have the right to access to the additional private insurance for the same premium;
- The prohibition of policies differentiation in pillar II;
- All insured persons will have the right to resign from the insurance contract
- The prohibition of premium differentiation based on such as age and health status of the insured person.

**Type of incentive:** The Ministry of Health distinguish between the financial and non-financial incentive of the voluntary health insurance system.

**Financial incentive:** The premiums for the voluntary health insurance, about 32 PLN (8 Euro) will kept on a low basis to attract the new scheme to the population because the price could be only guaranteed if 20% of the population purchase the health insurance under the pillar II. In case the number of insures increases, the price for the insurance goes down and the other way around. Furthermore the premium of the health insurance could be lowered through the co-financing by the employer (from resources gathered in the Enterprise Social Insurance Funds that is an obligatory institution, mandated in the Polish labour law). The insurance premium also depends on the introduction of a new tax reduction mechanism: It is planned that every person who buys the voluntary health insurance will be reimbursed one third of the premium by the fiscal office. **Non-financial incentive:** The insurance companies will be obliged to insure all patients; they are prohibited from discrimination of the insures due to such factors like age, health status, disability, social status (in fact the companies will rather collect premiums than really insure patients – the money they collect will be transferred to the NHF). The model based on the idea that patients purchase a voluntary health insurance from private insurance companies and not from NHF. This

stimulates patients to buy such insurance. It seems to be a solution that suggests patients that they buy something for themselves and not for the support of the NHF. Patients probably have much more trust in the private market; the real objective of the introduction of voluntary health insurance – i.e. to increase NHF resources – may hide for patients.

**Expected outcome:** The Polish government wants to increase the budget of the health care system if in case 20% of Poles would purchase the additional package, the health care budget would increase by 5 billion PLN – 1.25 billion Euros. The hospitals may receive more NHF funded budget allocation and will be able to reduce the Out-of-Pocket payments. In addition they could invest more money in terms of higher quality services for the patients who purchase the voluntary health insurance.

### Relevance for the Medical Insurance System in China

The Polish system idea to introduce private market mechanism using private voluntary medical insurance might be a useful tool for the Chinese Health Care and Medical Insurance System because the Chinese population like the private market approach and they would join the scheme if the offered benefit is attractive for them. The state has all the time the possibility to control the market throughout regulation and supervision which is usual in all European countries.

Comparative Table:

Medical Insurance System	NHF Poland	BMI China
Implemented in	1997	1998
Coverage	Entire Population	Urban Employees and retirees
Pooling	Central and District level	Individual accounts; county, city and province level
Benefit Package	Minimum package defined by law and purchased by the medical insurance	List of services, medicines and equipment
Co-payments for	Excluded services; accommodation; etc.	% of the service, medicine and equipment; accommodation; excluded services
State Voluntary Health	None	Yes, urban employees

Insurance		and retirees
Private Supplementary Health Insurance	Planned for 2008	None

The medical insurance system started in both countries in the end of the 90<sup>th</sup> and the systems are developed in different direction. However the results that have arisen showing similar problem in terms of the co-payments and the patient have to pay certain amounts out of their pocket. In China the system covers 30 to 50% depends on the financial situation of the province and the Poles face a pretty similar situation because a lots of services are not covered by the medical insurance (please note that in Poland the services should be free of charge).

Still the patient whether they are insured or not suffering from high co-payments in China. Reasons for that is that hospitals budgets are financed by around 10% of state subsidies, 30 to 40% by the medical insurance scheme and up to 100% out of pocket by the patient. The out of pocket payment come out of drugs sales and accommodation. The Ministry of Health analyzed the situation in order to countermeasure occurred problems in the health care system (see Chart 1).

	Urban	Urban	Rural	Rural
	2003	1998	2003	1998
Basic Insurance	30.4	-	1.5	-
Government	4.0	16.0	0.2	1.2
Labour Insurance	4.6	22.9	0.1	0.5
Cooperative Insurance	6.6	2.7	9.5	6.6
Commercial Insurance	5.6	3.3	8.3	1.4
Self payments	44.8	44.1	79.0	87.3

However the Ministry of Labour and Social Security identified the problem and established the “Supplementary Medical Insurance for Urban Employees and Retirees”.

### **Supplementary Medical Insurance in China**

In order to prevent a decrease in the current levels of medical care given to employees in particular industries, supplementary medical insurance may be established by enterprises as a transitional measure, in addition to participation in the basic medical insurance system. The portion of contribution to an enterprise supplementary medical insurance plan, which is less than 4% of total wages, shall be drawn from employee benefit funds. The portion of contribution that greater than the employees’ benefit funds may be included as

a business cost upon approval by the department of finance at the same level.

The payment of subsidies (typically by governments on behalf of civil servants or trade unions on behalf of participating members) is a supplement to the basic medical insurance system in China. When payment out of socially pooled funds has reached the upper limit, the excessive medical expense can be covered by the subsidy in a certain proportion. The ceiling of the subsidy is generally two hundred thousand Yuan (RMB 200.000) or so.

### **Conclusions:**

Still there is needs to co finance the medical expenditure of the patients for certain groups and one solution of solving the problem might be the extension of the supplementary insurance to other population groups. Another solution could be as well the introduction of a 2<sup>nd</sup> Pillar – Supplementary or voluntary insurance scheme public or private orientated. The Polish situation seems to be similar to the Chinese and there fore we wants to address the approach into the Chinese policy discussion.

### References:

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The Ministry of Health Directive from 7<sup>th</sup> of July 2006 on the Committee on the Legislation Changes Elaboration for regulation of functioning of the additional private health insurance