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PRIVATE HEALTH INSURANCE AS A SOURCE OF FINANCING THE HEALTHCARE SYSTEM IN POLAND

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Abstract The medical services market in Poland is financed mainly with funds from national health insurance, yet year by year, an increasing importance of private resources in financing health services can be noticed. Apart from common (national) health insurance, medical care is primarily financed directly by the patient and possibly by his employer (occupational medicine, additional private medical care). The purpose of this paper is to present the basic legal and market aspects of private health insurance in Poland, including a presentation of the structure of private healthcare expenses in Poland.

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Introduction

The most sensitive issue of healthcare policy has always been, and still will be, the issue of financing the healthcare system. The healthcare system is a whole composed of many different elements, variously interrelated, aiming at health-related objectives. In addition, the healthcare system should be viewed in the context of reflecting the reality (organization and functioning) of a given country. The primary manner of financing the healthcare system, adopted in a given state, is directly related to the healthcare system model adopted in that state. Common models of the healthcare system include:

1) Bismarck (insurance) model,
2) Beveridge (tax/budgetary) model,
3) Residual (market) model,
4) Siemaszko model.

Each EU country has one of two organizational healthcare system models, namely the Bismarck or Beveridge models. The Siemaszko healthcare system model functioned in Poland up to 1999, in which the state was fully responsible for providing healthcare services and their financing from the state budget. That model was replaced by an insurance model based on the Bismarck concept – with modifications – which was first introduced after the war by the act on common health insurance of 6th February 1997 (binding since 1st January 1999). The reform was based on the idea of departing from the budgetary system of financing healthcare and adopting an essentially insurance-type healthcare model. This model is based on insurance the purpose of which is to protect people against unpredictable events (disease) and the resulting loss of the family's material security. In return for the pre-paid premium, the insured person is entitled to specific health services. As a result, common health insurance remains the main source of financing healthcare in Poland, as it has been for many years. Theoretically, every insured person has the right to equal access to medical care with a wide range of services financed from public means. By law, each insured person is entitled to medical care financed with public means, in the form of guaranteed services. Yet in practice, the insured wait several months for an appointment with a specialist, or even several years for surgery (e.g. ophthalmologic or orthopaedic). The last few years have shown that hospitals and outpatient clinics often have money from the NFZ (National Health Fund) to last only for the first half of a calendar year. After summer holidays, a patient's chances of specialist treatment in a given year constantly decrease, and the waiting time for a medical appointment extends even to the following year. Unfortunately, in almost every healthcare system organization of the process of providing healthcare services is connected with limiting access to medical care. The objective is usually achieved with waiting lists and by means of a guaranteed services catalogue. Both those methods are also applied in Polish law, hence an insured person is entitled only to guaranteed services, and their availability depends on the waiting time. Common (public) health insurance covers most of Polish society, but interest in private medical care has been growing for years now. Private health insurance is also called commercial, market, or voluntary insurance. In EU countries, private health insurance has become standard. The development of private insurance in EU countries is supported by the state (e.g. through tax privileges). With the limited availability and constantly deteriorating quality of healthcare services financed with public means, private healthcare becomes an alternative. A patient can secure additional private medical care under a contract for providing healthcare services (prepaid medical care) concluded directly with a service provider from the medical services market, or by concluding a health insurance contract with an insurer. Prepaid care packages and insurance are offered in several variants of different scope and amount of fees/premiums. Generally speaking, the essence of private medical care is to provide a patient with quick and less formalized access (no referrals, etc.) to healthcare services specified in the contract (e.g. specialist consultation, or diagnostic tests).

Commercial health insurance is one of the sources of financing the healthcare system. The purpose of this paper is to present the basic legal and market aspects of private health insurance in Poland, including a presentation of the structure of private healthcare expenses in Poland.

Common health insurance

Under art. 68 of the Polish Constitution from 1997, everyone has the right to health protection, and also each citizen has the right of access to publicly funded medical services under conditions laid down in the act on health insurance. Particular care should be provided to children, pregnant women, people with disabilities and the elderly. With regard to patients' rights to healthcare services, the Constitution refers to the act which regulates the issues in detail. Since 1st October 2004, the issues of health insurance in Poland are regulated by the act of 27th August 2004 on healthcare services financed with public means (Dz.U. of 2008, No. 164, item 1027 as amended), further as a.h.s. (act on healthcare services) or the insurance act. The executor of common health insurance named in the above cited act on healthcare services financed with public means is the NFZ, and its chief principles assume equal treatment of citizens and social solidarity, providing the insured with free access to healthcare services and free choice of service providers. The act specifies the rights and duties of the insured, the principles, mode and times of applying for health insurance, determining health insurance premiums, paying, settling and reclaiming the premiums, keeping records of the insured, NFZ organization and operating principles, and the supervision and audit principles. According to the principle of social solidarity, the amount of premiums for health insurance does not affect the quantity, quality and type of services received. On account of that principle, the insured who use health services occasionally, finance the healthcare of the sick who take advantage of medical help more frequently.

An important amendment to the above cited act (act of 25th June 2009 amending the act on healthcare services financing) came into force on 12th August 2009. It introduced the concept of guaranteed medical services. The amendment also added provisions specifying the principles and mode of qualifying healthcare services among guaranteed medical services. The aim of the amendment was to substitute the negative range of services (art. 17 of a.h.s. and its annex was thus repealed) with a list of guaranteed medical services. A guaranteed medical service is a healthcare service fully funded or co-financed with public means, on principles and in the scope defined in the act. Generally, it may be claimed that the Polish patient – service recipient – has the right to guaranteed medical services. A service recipient is an individual person – patient – entitled to use/using health services. Both a minor and an adult patient who is an insured person as understood in the act on healthcare services financed with public means shall be considered a service recipient. Under the principles

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specified in the insurance act, the following persons have the right to use the services:

1) the insured, i.e. people who are:
   a) subject to obligatory health insurance,
   b) insured on a voluntary basis,
   c) members of families of people subject to health insurance or insured voluntarily,
2) and people other than the insured, i.e. people:
   a) with Polish citizenship who reside in the territory of the Republic of Poland and meet the income criterion defined in art. 8 of the act of 12th March 2004 on social assistance (Dz.U. of 2008, No. 115, item 728 as amended),
   b) entitled to health services under provisions on social security systems' coordination,
   c) with Polish citizenship who reside in the territory of the Republic of Poland and who are under 18 or are women during pregnancy, in labour or in puerperium.

In consequence of a person who is subject to obligatory insurance or insured voluntarily paying the premiums within the times and on terms specified in the act, such a person obtains the right to health insurance services along with his/her family members. Health insurance obligation shall be deemed met after the person who is subject to that obligation applies to the NFZ and pays the premium. The application is made by the tax remitter (e.g. in the case of an employee it will be the employer) and is addressed to the Social Insurance Company (ZUS). In return for paying health insurance premiums, the insured have the right to use statutorily defined health services free of charge or for partial payment. The health insurance premium is currently 9% of the premium assessment basis.

Within health insurance, the insured person has the right to health services corresponding to the requirements of current medical knowledge, within the funds owned by the NFZ. Based on art. 15 item 1 of the insurance act, service recipients have the right to healthcare services under principles set out in the act. The aim of the services is to maintain health, prevent diseases and injuries, detect diseases early, provide treatment and care for and prevent disability, or limit it. Services due to a recipient and aimed to maintain health, prevent diseases and prevent diseases include:

1) promoting healthy behaviour, in particular by encouraging individual responsibility for one's own health,
2) early, multispecialty and comprehensive care for children at risk of disability or the disabled,
3) preventive medical examinations for early diagnosis of diseases, with particular focus on cardiovascular diseases and tumours,
4) health promotion and prevention, including dental prophylaxis for children and adolescents under 19 years of age,
5) conducting preventive examinations for pregnant women, including prenatal testing recommended in at-risk groups, and for women over the age of 40, and dental prophylaxis,
6) preventive healthcare for children and adolescents in their learning and upbringing environment,
7) performing preventive vaccination,
8) performing medical tests within sports medicine, involving children and adolescents under 21 years of age who are amateur athletes, and professional sportsmen between the age of 21 and 23.

Art. 15 item 2 of a.h.s. lists types of guaranteed services provided to recipients and financed with public means. Under the above provision, service recipients shall be provided with guaranteed services within the following scope:

1) primary healthcare,
2) outpatient specialist care,
3) hospital treatment,
4) psychiatric care and substance abuse treatment,
5) medical rehabilitation,
6) nursing and attendance benefits within long-term care,
7) dental treatment,
8) health resort treatment,
9) supply of medical devices which are orthopaedic objects and supplementary accessories,
10) medical rescue,
11) palliative and hospice care,
12) highly specialised medical services,
13) health policy programmes,
14) drugs.

In view of the above regulations, it may be stated that the service recipient (patient) has a right to obtain healthcare services eligible as guaranteed under the law. Guaranteed services are financed with public means. They are completely free of charge for the insured, or partly paid by them. The catalogue of services from art. 15 item 2 of a.h.s. is a general one.

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More detailed lists for the particular categories of services are included in relevant executive regulations of the insurance act, issued in 2009. Healthcare service are classified as guaranteed services based on their evaluation, which considers criteria defined in the act (such as their significance for the citizens' health, clinical efficacy and safety, the ratio of cost to the health effects obtained). Classifying particular services within the group of guaranteed services lies with the competencies of the Minister of Health. The Minister of Health classifies the services on receiving a recommendation of the President of the Agency for Health Technology Assessment in Poland (AOTM). Primary healthcare and outpatient and stationary specialist services are financed from health insurance. Primary healthcare means providing preventive, diagnostic, therapeutic, rehabilitation and nursing health services of general and family medicine, granted within outpatient healthcare. Specialist services, in turn, are healthcare services in all fields of medicine with the exception of services provided within primary healthcare (e.g. laryngology, cardiology, orthopaedics, ophthalmology, surgery). Specialist services may be provided in outpatient or stationary forms.

Healthcare services in hospitals and specialist services in outpatient care are provided by the order of registration on the days and in the hours set for providing them. If a service cannot be provided immediately, the patient is entered on a waiting list. If the state of the health condition of the insured person changes so as to indicate the need to have the service provided earlier than planned, the patient informs his/her service provider. If that follows from medical criteria, the service provider adjusts the time for providing the service as needed and immediately notifies the patients about the new date. Waiting lists are, in practice, a legal form of limiting the availability of guaranteed services.

The service recipient may obtain a guaranteed service (financed with public means) only from a provider who has a contract agreement with the NFZ. Under art. 132 of the insurance act, the basis for providing healthcare services financed with public means by the Fund is a contract for providing healthcare services concluded between the service provider and the manager of the Fund's regional branch. The amount of the Fund's total liabilities arising under contracts concluded with service providers cannot exceed the amount of costs envisaged for that purpose in the Fund's financial plan. The Fund concludes contracts for providing healthcare services after tender or negotiation proceedings are completed. The procedure of concluding contracts is governed in detail by the regulation of the Minister of Health of 15th December 2004 on the way of announcing proceedings concerning concluding contracts for providing healthcare services by the NFZ, invitations to participate in negotiations, tender submission, appointing and disbanding the jury, and its tasks (Dz.U. of 27th December 2004).

The insurance act specifies the general scope of guaranteed services due to the insured. In practice, however, there may be a variety of problems with the scope of services due to the insured because detailed principles for accessing the guaranteed services are additionally regulated by executive regulations to the insurance act and by the provisions of contracts concluded by service providers with NFZ.

The Legal Nature and Types of Private Health Insurance in Poland

One of the forms of disease risk management is insurance. Health insurance should be understood as insurance against the risk of expenses related to the need to use health services (Stachura, 2004). Health insurance is offered as a product within the insurance activity of specialized entities. Insurance activity means offering and providing cover in case of a risk of fortuitous events (Stawowiak, 2005, p. 9-10). A fortuitous event is a future and uncertain event which is independent of the insurer (e.g. disease), and which results in damage to personal or material interests. Private health insurance in Poland can be offered only by insurance companies or mutual insurance societies. The offer of an insurance company is purely commercial, while the product of a mutual insurance society implements social objectives (protects the members of the society against unpredictable treatment costs).

Insurance is generally divided into property and personal forms, according to its object. The object of property insurance may be any property interest which does not contravene the law and which may be evaluated in monetary terms. Personal insurance differs from property insurance, mainly in the subject of their coverage, which is the life and health of the insured. The conditions for conducting personal insurance and property insurance activities are

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determined mainly in the act of 22nd May 2003 on insurance activity (Dz. U. No. 124, item 1151 as amended). An insurance company shall grant insurance coverage under a contract of insurance concluded with an insurer. The basis for the patient (customer) to be covered by private health insurance is an insurance contract with the insurer. An insurance contract is currently voluntary in nature. Nowadays the Polish law has almost no regulations referring only and directly to a (private/supplementary) health insurance contract, hence general provisions on insurance, including the Civil Code, shall be applied here. The insurance contract is governed by the Civil Code (Art. 805-834). The Civil Code regulates insurance contracts only in general due to the range of various types of insurance which require using many specialist solutions. It is a contract under which the insurer commits, within the activity scope of its company, to provide a specified service if an event (accident) provided for in the contract occurs, and the policyholder commits to pay the premium. For example, if the insured person becomes sick and requires consultation with a specialist doctor, the costs of the visit will be covered by the insurer. The insurance contract is a nominate contract, and belongs to reciprocal contracts and contracts for valuable consideration. Moreover, it is a consensual (i.e. to be concluded, it requires only a unanimous declaration of will of both parties) and adhesion contract (i.e. it is concluded as a rule by accessing the proposed terms), and also qualified (i.e. one of its parties is a professional). In the insurance relation there are basically three entities, i.e. the insurer, the policyholder and the insured. The insurer is the entity (insurance company), which by agreement assumes the risk of incurring consequences of an insurance accident specified in the contract. In accordance with the insurance act, an insurance company may function only in the form of a joint stock company or a society of mutual insurance. The policyholder is the entity that concludes the insurance contract with the insurer. It may be any natural or legal person. The insured person is the one whose assets (property, health, life) has been covered by the contract of insurance. In most cases the policyholder and the insured are the same person.

The basic services of parties to the insurance contract include financial performance of:

1) the policyholder, who is the payer of insurance premiums,
2) the insurance company, which is the payment of the agreed compensation or benefit.

The size of the insurance premiums is set by the insurance company after evaluating the underwritten risk. The insurance premium amount is set so as to at least ensure execution of all liabilities under insurance contracts and coverage of the costs of the insurance company conducting the insurance activity. The premium is calculated for the duration of the insurer liability period. If not agreed differently, the premium should be paid simultaneously with conclusion of the insurance contract, and if the contract is effective before the insurance document is delivered, then within 14 days of its delivery. In accordance with art. 812 § 1 of the Civil Code, before concluding the insurance contract the insurance company must deliver the text of the general insurance conditions to the policyholder. The General Terms and Conditions of Insurance (General Terms) are the conditions adopted by insurance companies upon which the company underwrites the risk declared by the customer. General Terms describe the situations in which the insurance company may refuse to pay compensation or may reduce it as needed. The Terms also enumerate situations in which the company is not held liable if damage occurs. Moreover, General Terms define the obligations of the insured person and consequences of not complying with them.

The insurance company pays the claims or benefit when the claim of the beneficiary under the insurance contract is admitted in consequence of the findings made in the proceedings, or an arrangement made with the insured, or a lawful ruling of a court. Unless agreed otherwise, the insurer's liability begins on the next day after the contract is concluded, but not earlier than the next day after the premium or the first instalment thereof is paid. Basically, the insurer should fulfill its obligation within thirty days from the date of notification of the event.

Until quite recently, the market of insurance products related to medical care was very modest (it essentially covered only insurance of medical expenses for people going abroad and insurance of daily hospital treatment). Currently, the health-related insurance market covers the insurance of:

1) health damage,
2) serious diseases,
3) hospitalization expenses,
4) convalescence and rehabilitation,
5) nursing,
6) medical expenses (Osak & Więckowska, 2005, p. 164-174).

Voluntary private health insurance comes in two variants, i.e. individual and group insurance. The development of private health insurance in the Polish market started with group insurance. Due to increasing interest of employers in securing private medical care for their employees, insurance companies have introduced a new product – group health insurance. Nowadays, the offers of insurance companies include more and more often offers of individual health insurance which ensures access to medical care in Poland. Depending on the offer, the list of guaranteed services is very diverse, and it is usually much poorer than the one covered by common health insurance. Yet the advantage of private insurance is still the short time of accessing medical services (e.g. an appointment with a specialist within 48 hours). One may distinguish the following types of health insurance by their scope:

1) substitutive (parallel and competitive towards public insurance),
2) complementary (it guarantees services not covered by common insurance),
3) supplementary (it guarantees faster access to a wider package of services) (Holly & Lewiński, 2004, p. 7).

Depending on its variant, the insurance contract can be concluded with an employer for his/her employees (it may also cover members of their families) or with an individual customer (natural person). Individual insurance sometimes provides coverage for children and spouse with the insurance. Only a natural person may be covered by health insurance. The range of potential insured persons is limited with the formal criteria to be met by these persons (Osak & Więckowska, 2005, p. 173). The most important restriction to the offer is the age of the potential insured person (as of the day when the insurance coverage begins), who generally may not be older than 60-65. It is also possible to establish a minimum age for taking out an insurance (usually it is the age of 18). Beside age, health is the limiting criterion to conclude the insurance contract (that concerns particularly the absence of specific diseases or the time passed since their treatment). As concerns the object of insurance, it is related to the customer's medical condition and his/her demand for health services. It is mainly about comprehensive financial hedging of risk associated with disease. A contract for comprehensive health insurance guarantees access to specific health services. The insurance coverage is always further clarified by indicating the guaranteed services. The analysed insurance product is optional, as within the offer of one insurer the product occurs in several options (e.g. a basic or extended one). As concerns the manner of performing the insurance company's obligations, the prevailing way is to guarantee direct access to health services provided in medical institutions cooperating with the insurer. The principle which occurs in almost every product is unlimited access to primary healthcare. An element differentiating the scope of insurance both between variants and between insurers is access to specialists and diagnostic tests. The differences concern mainly the number of available medical specialties (from just a few to about a dozen) and the number of diagnostic procedures. An innovative element is the access to hospital services.

Currently in Poland there is no normative act which directly concerns private health insurance, although there were drafts (Migdalski) concerning the issue (recently a government draft law on additional health insurance in 2011), and private insurance is offered and contracts concluded on generally applicable terms.

Private Expenses on Healthcare

Each year, the Main Statistical Office prepares reports on healthcare. One of such studies is the report titled Health and healthcare in Poland. It contains information about the level of expenditure by government institutions and local governments (including the NFZ), i.e. public expenses, and the expenses of the private sector and the Rest of the World sector.

Total expenses on healthcare, i.e. current and investment expenses, amounted to 99 billion PLN in 2009, which represented 7.4% of the Polish GDP. In the time period presented in table 1, those expenses were increasing. It is enough to mention that they have almost doubled since 2003. Considering the dynamics of changes in public and private expenditure on healthcare, public expenses increased from 2003 to 2009 by 91.4%, whereas private increased by 64.8%. Analysis of changes in healthcare expenses as compared to GDP changes shows clearly that besides LGU expenses and direct expenses of households, all other categories grew faster than GDP.

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Current private expenses on healthcare increased from 15.5 billion PLN in 2003 to 25.6 billion PLN in 2009. A significant part are direct expenses of households. That expenditure constitutes less than 2% of GDP and is gradually growing, which suggests that the trend may be expected to continue in the future.

Table 1: Total expenses on healthcare in Poland in 2003 and between 2007 and 2009

	2003		2007		2008		2009	
	millions PLN	% of GDP	millions PLN	% of GDP	millions PLN	% of GDP	millions PLN	% of GDP
GDP Specification	842120	100	1176737	100	1272838	100	1343366	100
Current public healthcare expenses including expenses of	34880	4.14	50016	4.25	60214	4.72	667 64	4.97
the state budget	2472	0.29	4779	0.41	5391	0.42	5935	0.44
LGUs	771	0.09	970	0.08	1014	0.08	1088	0.08
social security funds	31637	3.76	44268	3.76	53809	4.22	59741	4.45
Current public expenses including	15547	1.85	20872	1.77	23224	1.82	25622	1.91
direct expenses of households	13911	1.65	18337	1.56	20025	1.57	22018	0.64
other expenses	1637	0.19	2535	0.22	3199	0.25	3605	0.27
Total current expenses	50427	5.99	70888	6.02	83438	6.54	92386	6.88
Investments	2194	0.26	3585	0.30	5869	0.46	6589	0.49
Total expenses on healthcare	52632	6.25	75665	6.43	89307	7	98975	7.37

Source: Health and Healthcare in Poland in 2010

Total expenses on healthcare in Poland in 2009 constituted over 7% of GDP. It is not an impressive result, compared to other countries in the world. Data presented in chart 1 clearly show that in that respect we are significantly behind the best, and also countries such as Slovakia, Slovenia, the Czech Republic or Hungary are ahead of us.

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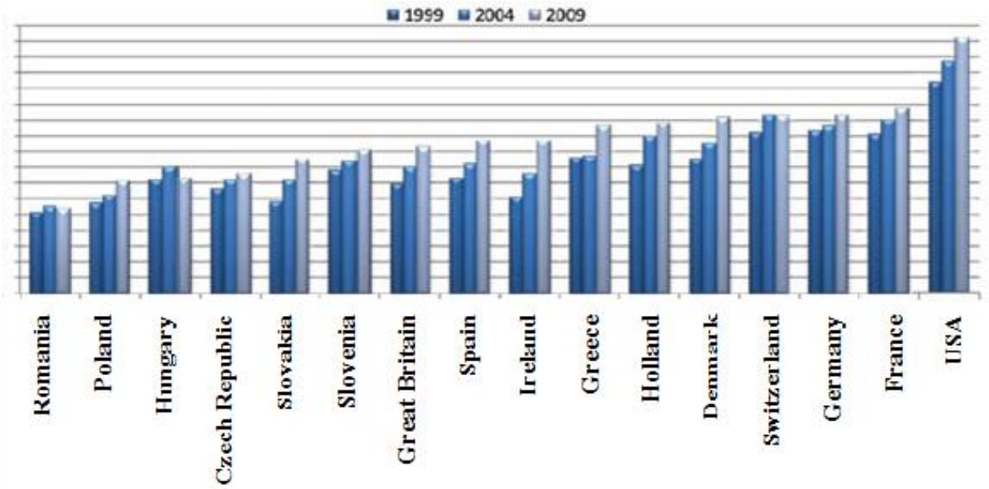
Chart 1: Total expenses on health as share of GDP in 1999-2009 (%)



Source: Role of private health insurance in the healthcare system. How it affects access to services, innovation and drugs – key theses and recommendations, Polish Insurance Association, report trailer prepared by the consultancy and training company Sequence HC Partners, p. 4

Global expenditurs on healthcare throughout the world have reached the level of $5 trillion, which makes up 10% of the world's gross income (Polish Insurance Association, p. 4). The greatest spending on that purpose in relation to GDP is noted in the United States. Poland is very far behind. As compared to the USA, we spend less than half the amount. Considering the structure of the expenses, it is clear to see that public expenses definitely prevail in Poland.

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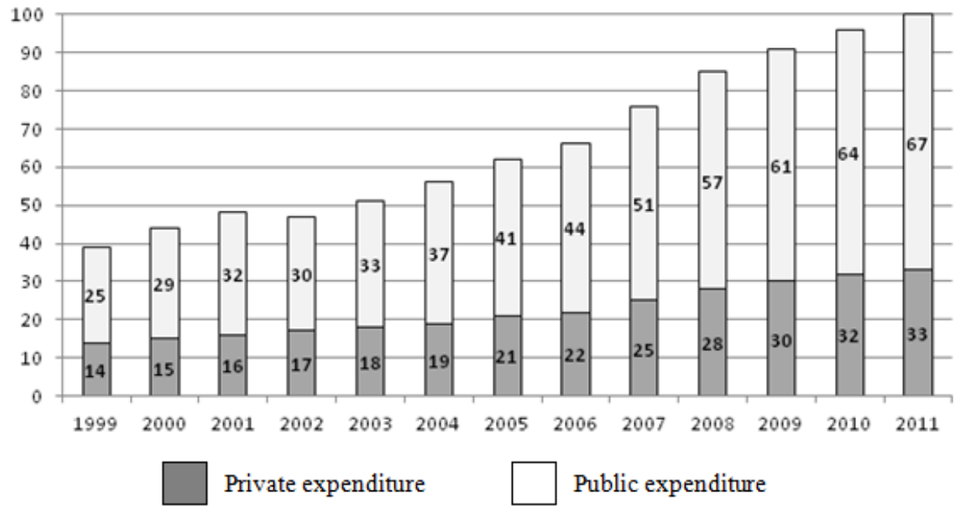
Chart 2: Expenses on health in Poland in 1999-2011 (in billions PLN)

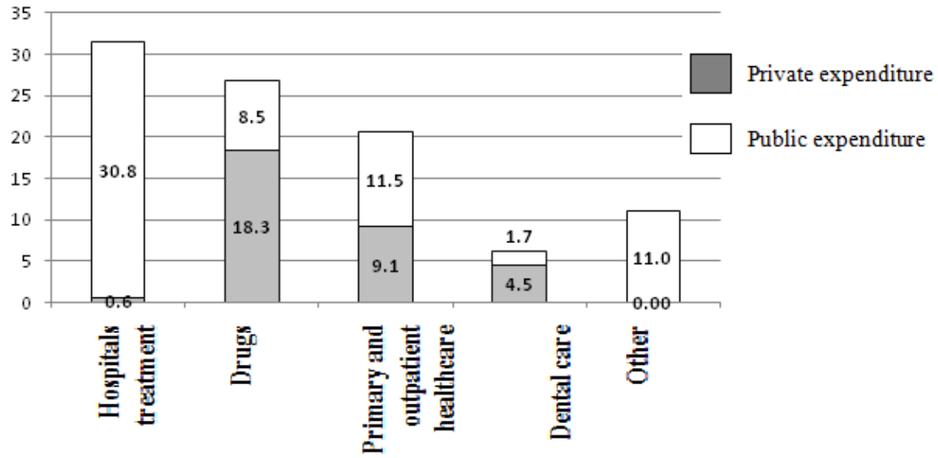


Source: Role of private health insurance in the healthcare system. How it affects access to services, innovation and drugs – key theses and recommendations, Polish Insurance Association, report trailer prepared by the consultancy and training company Sequence HC Partners, p. 5

Expenses on healthcare in Poland reached 100 billion PLN in 2011. The above chart shows that over the last 12 years those expenses have risen one and half times. In the expenditure on healthcare, private expenses are of smaller significance, accounting for about 1/3 of all expenses. The structure of expenses over the 12 years presented in chart 2 has undergone a slight change. In the late 20th century, the share of private expenses in total expenditure oscillated around 36%, and now it has fallen by about 3 percentage points.

Private expenses on healthcare are primarily incurred on drugs. Further, private means finance treatment or all-day healthcare for people who do not require round-the-clock or all-day treatment. Next in line are expenses on dental care.

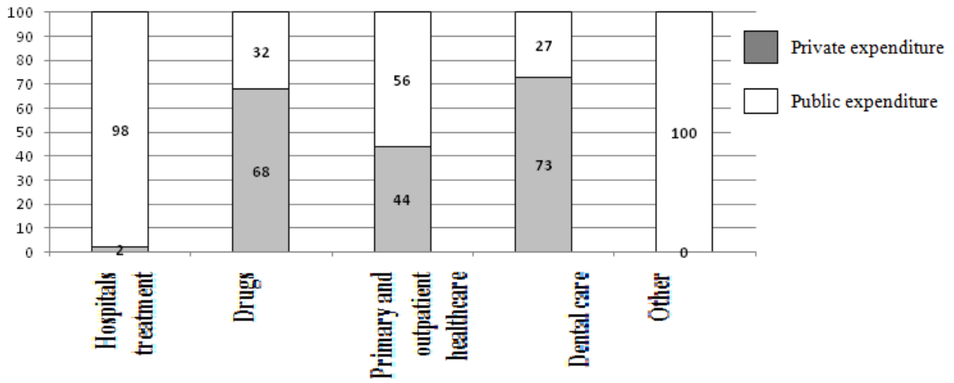
Chart 3: Allocation of public and private expenses on health in Poland in 2010 (in billions PLN)



Source: Role of private health insurance in the healthcare system. How it affects access to services, innovation and drugs – key theses and recommendations, Polish Insurance Association, report trailer prepared by the consultancy and training company Sequence HC Partners, p. 6

Very interesting is the structure of private and public expenses covering expenses on health.

Chart 4: Allocation of public and private expenses on health in Poland in 2010 (in %)



Source: Role of private health insurance in the healthcare system. How it affects access to services, innovation and drugs – key theses and recommendations, Polish Insurance Association, report trailer prepared by the consultancy and training company Sequence HC Partners, p. 6

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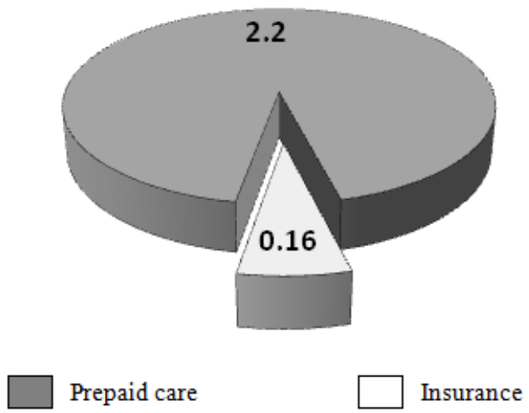
When analysing the data presented in chart 4, it should be noted that a vast majority of expenses allocated to dental services comes from the patients' private means. It is similar with buying drugs. In the latter case, almost 70% of expenses are financed with non-public means. A little less than half the funds for treatment or all-day healthcare for patients who do not require round-the-clock or all-day care are financed privately.

Additional private healthcare can be secured under a contract for providing healthcare services, i.e. prepaid care, concluded directly with the service provider of the medical services market, or by concluding a contract of medical insurance with a selected insurance company.

Chart 5: Private expenses on prepaid care and insurance in 2009 (in billions PLN)



Source: Polish Insurance Association (PIU)

From the total amount of 30 billion PLN, which were allocated to healthcare from non-public means in 2009, a little over 2 billion PLN was allocated to prepaid care. Much less popular was insurance – about 160 million PLN was spent on it in that period. The two forms of financing healthcare are characterized below.

Brief Description of Comprehensive Private Medical Care Offers

In practice, comprehensive private medical care offers take the forms of either prepaid care (which is becoming less and less popular) or health insurance.

The market of prepaid care services has been developing in Poland since the mid-1990s. Prepaid care means a healthcare centre selling a specific range of medical services directly to the potential recipient. In most cases, the parties in the transactions are private clinics of various size with different territorial range, and companies which purchase such service packages for their employees. The amount of the subscription fee depends mainly on the scope of services offered, and ranges from a few dozen to several hundred PLN a month per person.

Within the framework of the provided services, the customers can get not only services within primary healthcare or specialised outpatient healthcare,

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but also diagnostic tests or health prophylaxis. Of course, the specific scope of services depends on the amount of the fees and the scope of services specified in the contract between the service provider and the employer. Higher fees can e.g. give access to all or most available specialists, more specialised examinations, such as CAT scans or magnetic resonance imaging, access to all specialists and to rehabilitation, and sometimes also dental services. Most prepaid packages include also services within occupational medicine.

Initially, the prepaid care offer took advantage of the limitations to the availability of services which were common in the public system (queues, poor quality of services, problems with obtaining referrals, etc.). Eliminating those barriers in access to medical care has given private service providers a competitive advantage. Yet in time, new products appeared which constituted a successful combination of benefits in kind and cash. They were an alternative for the public offer and not only an addition to services guaranteed in the common system (Wierzbicka, 2008, p. 89).

Using prepaid care gives employers considerable benefits. Among them one may mention reducing staff sickness absence, an effective instrument of managing particularly human resources, and it may also be used as an incentive scheme component.

Insurance companies offer their customers a wide range of health insurance types. As in the case of prepaid services, the quality of the offer depends on the terms on which the contract is concluded. Solutions proposed by particular insurers are similar, yet there are some aspects which require particular attention, because they can prove the quality of the policy.

The first important point of the policy is the object of insurance, which is the employees' health. It may be extended to protect their families. Insurance protection coverage provides the insured with medical services in the territory of the Republic of Poland, but for an additional fee that can be extended to other countries of the world.

Another important point of the policy which proves its value is the range of services offered. Most insurers offer several insurance variants, each with a different range of services depending on the premium amount. The sum of insurance and limits on particular services are also important. For instance, the insurance may cover morphological tests, but they may be limited to a maximum of 2 times a year. The same applies to other services, e.g. medical transport from the place where the insured fell ill to a hospital, nursing care after the insured is hospitalised up to a specific sum (the higher the sum, the fuller the protection). Another important issue is the deferred period. The deferred period is a temporary exclusion of the insurer's liability. It usually occurs only in the first year of concluding the insurance contract. The deferred period is calculated from the first day of covering the insured by insurance protection. It is possible to forgo deferred periods.

Another important issue is the distribution and number of units where employees can use the services. The more units, the easier it is to make an appointment and the greater the comfort of using the insurance.

Each insurer which offers health insurance in the Polish market has a slightly different offer, but it is possible to note some trends. Namely, each of them gives the insured a choice of more than one option. In most cases, the companies prepare a range of basic services, and other packages extend that range, which in turn leads to higher premiums. Insurance is offered in individual and group variants, as well as individual and family variants.

Insurers supplement the policies with additional contracts offering insurance coverage in the event of the insured's hospitalization, serious illness, or medical expenses abroad. Employers often treat that product as a component of an attractive non-financial package which helps acquire and motivate employees. The offers of insurers often make it possible to benefit from a number of medical facilities. Insurers can sign agreements with a number of entities to have their clients use the services there. In the case of prepaid care, clinics hope to attract the customers only to itself. Most often, policies provide a more comprehensive care extended to include hospital treatment. With insurance (as follows from the principle of their activity), risk of injury has a considerable impact on the premium amount, so the policy's price can be affected by the age and medical condition of the customers. That is unlikely to happen in the case of prepaid care, where those characteristics are not taken into account. Insurers use the deferred period to avoid paying compensation for damages which occurred before the date of concluding the contract.

The value of the market of health insurance and prepaid care packages in our country is significantly smaller as compared to the overall market of private

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health services. The main barriers to the development of such solutions are: low awareness among Poles, low incomes and high unemployment, low confidence in commercial solutions concerning healthcare, or bad habits of the “envelope-like” financing of health service.

Under Polish law, the medical services market in Poland is financed mainly with the funds from common health insurance. Still, practice shows a constantly increasing participation of private funds in financing health services. Beyond common health insurance, medical care is primarily financed directly by the patient and sometimes his/her employer (occupational medicine, additional private medical care) (Paszkowska, 2004). Both the condition of public healthcare, higher prosperity of the society and higher insurance awareness help the Polish private insurance sector develop more and more dynamically. The market of private medical care is one of the fastest growing sectors in the entire region of Central and Eastern Europe. The growth rate of around 20% per year should continue for the next several years, as market participants constantly try to meet the rapidly growing demand, especially in the field of specialised care and hospital care. These two areas shall be the main driver of growth (Grzywińska). Poles already learned many years ago that if they wanted to be provided with high-quality treatment delivered on time, they had to buy it themselves. It is proven by the more than 30 billion PLN yearly spent on treatment from their own private means. As both Polish and world studies show, the deficit of money in public healthcare will get bigger, and the waiting lists for services will continue to grow. There are three factors that cause that, and they are observed not only in Poland. These are: an ageing society, medical technology progress (treatment costs will continue to grow) and increased social expectations. Even without changes in public healthcare, the higher quality and better access to medical services will make private health insurance a necessity within the next few years.

In the current situation of Polish healthcare it is definitely necessary to promote private health insurance (especially group insurance), as well as pass a law on voluntary individual health insurance which would be complementary or supplementary towards public insurance, and which would be available to any patient on reasonable terms. The development of commercial health insurance is undoubtedly related to the population’s income level. So far, it is mainly city dwellers with income higher than the national average who use private medical services. The market is driven mainly by corporations which offer to their employees healthcare in private clinics – sometimes even for their entire families.

Healthcare system financing has always been, and will continue to be a major economic and social problem for many countries. To resolve the social conflict resulting from the state’s financial capacities and patients’ expectations, the principles of healthcare functioning in Poland ought to be regulated systemically. Undeniable opportunities for rationalising the healthcare financing system are private insurance, patients’ co-payment for some services, and efficient management of resources both by the NFZ and – above all – by service providers.

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