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Title: What do Polish patients pay for?

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SUMMARY

In Poland, the low level of health care financing from public funds is becoming more and more voiced and increasingly accepted as an argument not only for rising health insurance contribution, but also for extending the scope of private funding. The analysis of out of pocket expenditure on health, as well as individual willingness to pay for health services may facilitate the assessment of space for the development of patient payment system.

The objective was to analyze the level and the structure of out of pocket expenditure on health in Poland as well as health care consumer characteristics influencing payments for health care and willingness to pay. The analysis rely on various sources of data i.e. macro data from comparative international statistics, aggregated micro data from the household budget surveys of the National Polish Statistical Office (GUS) and micro data form the representative survey carried out in Poland as a part of project ASSPRO CEE 2007. In Poland during the last decade, despite the increase in the level of out of pocket expenditures, their share in total health spending declined.

In the structure of out of pocket expenditure, spending on pharmaceuticals dominates. The expenditure on services most often refers to paying for outpatient specialists' services, rehabilitation services and dental care, often in private sector. Out of pocket expenditures are the highest among population groups with high health needs i.e. pensioners, chronically sick individuals (they pay mostly for pharmaceuticals) but also among individuals with higher income (they pay more often for services). Polish consumers do not object to co-pay for health services with good quality and quick access. However, greater stated willingness to pay characterized younger people, those with higher income and better health status.

Introduction

Health care consumers' individual expenditure on health is a constant subject of policy interest and research. Its analysis provides a basis for the assessment of health services funding and it is an essential element in conducting a rational and equitable health policy.

Analysis of individual spending on health is on the one hand an expression of concern about the standard of living of the population and it serves as justification for policies against poverty. High spending on health, called catastrophic, may in fact lead to a reduction of expenditure on other important social needs such as food or education, and in some cases lead to extreme poverty. On the other hand such analyses are used to assess the space for the development of private health care sector. Especially in countries with high level of public expenditure on health (e.g. continuing in some post-communist countries), such analyses favor the recognition of trends and tendencies for private funding of health care.

In Poland, the low level of health care financing from public funds (only about 4.6% of GDP) is becoming more and more voiced and increasingly accepted as an argument, not only for rising health insurance contribution, but also for extending the scope of private funding, whether in the form of greater cost-sharing, or more often in the form of private health insurance. Thus, in this brief we look in details at out of pocket expenditures on health in Poland, their scale, structure, as well as individual willingness to pay for health services.

Data sources

The analysis presented in this brief rely on various sources of data:

- Macro data: comparative statistics from OECD health database and National Health Account for the years 2002-2009 (both rely on the same methodology)
- Aggregated micro data: from the *module household budget surveys* of the Central Statistical Office (GUS) on households health care use and health expenditure for the years 1999, 2003, 2006, 2010
- Micro data: from the survey among representative samples of the national adult population aged 18 years and older carried out in Poland (along with other surveys in five CEE countries i.e. Bulgaria, Hungary, Lithuania, Romania and Ukraine) in July 2010 as a part of project ASSPRO CEE 2007

Size and dynamics of out of pocket health expenditure in Poland

In Poland, out of pocket health expenditures account for a substantial share in the total expenditure on health (22%) and their level continues to grow. Between 2002 and 2009, their nominal growth amounts to 69%, and real growth (adjusted growth to remove effects of price increase in the health sector) was 43%. Despite the increase in the absolute size of out of pocket spending their share, after the continued growth during the 90s, declined in the last years. It was an outcome of greater increase in public spending on health due to systematic rise of health insurance contribution rate (by 0.25 points per year till 2007), and then the decisions of the government to increase salaries of medical personnel (in the years 2008 - 2009).

According to macro data statistics, a significant share of out of pocket expenditure is spent on drugs. In Poland, the financing of drugs from individual income is very high (60.8%), the highest among OECD countries. It is due to not only the low level of reimbursement from the National Health Fund (NFZ), but also relatively high expenditure on OTC pharmaceuticals and dietary supplement. This tendency can be explained with the phenomenon of self-medication, induced by both, restrictions on access to the physicians and hurried lifestyle (lack of time to see a doctor), reinforced by advertising of medicines in the media.

Household out of pocket payments on health

The data of the Central Statistical Office on average individual household expenditure show that dynamics of household expenditure on health is high, higher than growth of the total consumer spending. This is a consequence of relatively high price index in the group of health products and services as well as the increase in the use of paid services, particularly outpatient specialist care.

The greatest percentage of household health expenditure is spent on pharmaceuticals (approximately 64%). The increase in the share of these expenditures was particularly strong in the years 1999 - 2006, by almost 20 percentage points. In the last few years slight reduction is observed.

Spending on outpatient health care takes the second place in the structure of household health expenditure (28%). They are related primarily to the use of dental and diagnostic services (laboratory tests), which more and more frequently are the subject of patient payments. Since the end of the past decade, patients have to pay also for care provided in the evening, at night and on holidays, which contributes to the increase in household health expenditure.

The lowest share in household total health expenditure represents expenditure related with patient hospitalization, which after a period of steady growth, began to decrease significantly in last few years. It results from, on the one hand, the introduction of legal restrictions on implementing internal rules of subsidizing hospitals by patients (e.g. in form of so-called bricks), and also reduction of various types of informal patient payments as the effect of the Polish government anti-corruption programs and actions in health care .

Informal gratitude payments in kind (in the form of gifts and flowers) account for a small and declining share of household expenditure on health (less than 1%) and they are slightly more common among households with disable or chronically sick members or members who have experienced serious health problems.

The average estimated level of out of pocket health expenditure is the highest, in both absolute and relative terms (in proportion to total consumer spending), in the households of pensioners. This is related to the specific structure of consumption in older households. In the structure of pensioners' health expenditure, spending on pharmaceuticals s prevails, rising up to 80%.

Another social group characterized with high out of pocket expenditure are the disabled (people receiving disability benefits mostly disability pensions). They also spend much of their health budget on pharmaceuticals. The third largest out of pocket expenditure are in the households of self-employed. However, self-employed individuals allocate their resources differently. In the structure of their health expenditure, spending on outpatient specialist care is substantial, while the share of expenditure on pharmaceuticals is lower (about 50%). It can be explained by the fact that households of self-employed are characterized with the highest average income and the analyses of individual spending across different income groups show that in the households with the highest income more resources is spent on visits to specialists, dental services and rehabilitation.

Overall, the variations in the structure of health expenditure across households results to a large extent from the differences in households health needs. Unexpected serious health problems increase the expenditure on private visits to specialists and medical tests (Diagnostics imaging). In households with chronically sick member significantly more funds is spent on drugs and laboratory tests. Expenditure on drugs dominates also in the in households with disabled persons. Additionally in this household expenditures on rehabilitations are also significant. The table below summarizes the key differences in the structure of average health expenditure (in percentage points) of households with different health problems compared to all households.

Table 1. Differences in the structure of average estimated out of pocket expenditure (in percentage points) of households with different health problems compared to all households.

	1999	2003	2006	2010
Appearance of serious health problem	Specialist: +3,6 Medical tests: +0,7	Specialist: +1,5 Medical tests: +0,6 Rehabilitation*: +0,5	Specialist: +3,8 Rehabilitation: +0,7 Diagnostics imaging: +0,4	Specialist: +1,3 Rehabilitation: +0,4 +0,5 (home rehabilitation) Diagnostics imaging: +0,6
Chronic illness	Pharmaceuticals: +9,4 Medical tests: +0,9	Pharmaceuticals: +11,2 Rehabilitation: +0,9	Pharmaceuticals: +7,5 Rehabilitation: +0,5 Medical tests: +0,4	Pharmaceuticals: +7,2 Medical tests: +0,4
Disability	Pharmaceuticals: +9,8	Pharmaceuticals: +14,3 Rehabilitation: +1,1	Pharmaceuticals: +13,8	Pharmaceuticals: +15,8 Rehabilitation: +1,1

*Note: data on rehabilitation and medical tests refer only to outpatient care services.

Individual payments for health care services

The analysis of patient individual payments for health care services indicates that majority of health care users in Poland do not pay for health care services, neither formally nor informally. Yet, the most common patient payments among the users are formal payments for outpatient physicians' services (reported by 19.6% of users). The median value per 1 visit is 50 PLN. Since Polish patients are not obliged to pay formal fee when visiting a physician within the publicly financed health care system (they may however pay for some diagnostic tests, certificates), the reported formal payments are rather related to the use of physicians' services in a private sector.

Formal patient payments for hospital services are relatively less common among the users (reported by 8.6% of users), though their median value per hospitalization is higher (180 PLN). It can be explained by the fact that, unlike outpatient services, using hospital services in a private sector is less prevalent. Furthermore, in publically financed hospital there is no patient cost – sharing (in some cases patients may only choose to pay formal fee in exchange for additional service, or services with higher standard e.g. a single room, family delivery but the right to charge patients has been recently restricted).

With regards to informal payments the reverse patterns is observed. These payments are more common in case of hospital care than outpatient services (reported respectively by 16.7% and 6.7% of users). Likewise formal payments, the median value of informal payments is higher for hospital care (approx. 126 PLN per 1 hospitalization) than for outpatient care (20 PLN per visit), though overall their level is lower compared to formal charges.

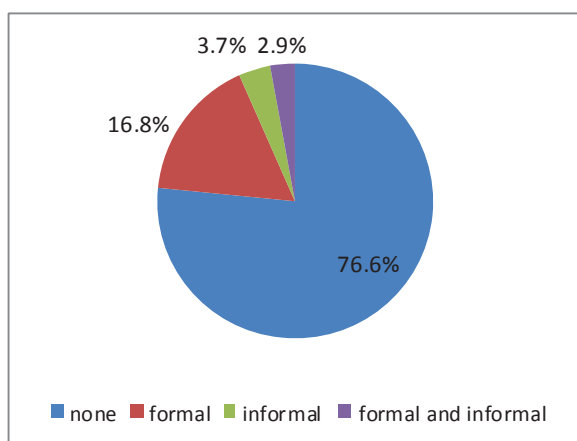


Fig.1 Paying for outpatient physicians' services (percentage of health care users)

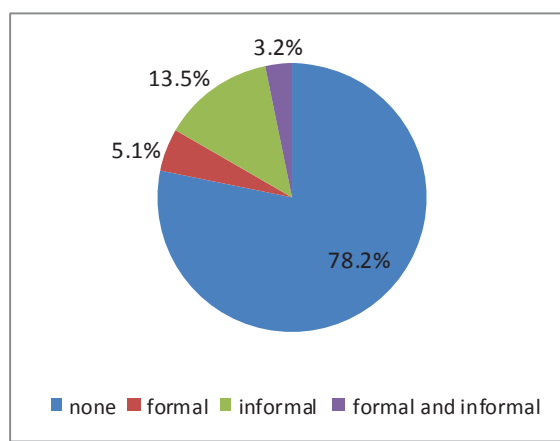


Fig. 2. Paying for hospital services (percentage of health care users)

The factors influencing the most prevalent payments among Polish patients i.e. formal payments for outpatient services are patients age, income as well as health status and resident place. Those who are younger are more likely to pay formally for outpatient services. The risk of paying increases also with the income level, however, it decreases with health status improvement (for those with good health, it is reduced by 60 % compared to those with bad health).

There is no statistically significant association of payment with education level however the results indicate that prevalence of payments increases with higher education level. These findings confirm that patients who pay for health care services are often those who in case of increased health need (illness) can afford to purchase services with quicker access (often in private sector).

Willingness to pay for health care services

Most health care consumers in Poland are willing to pay an official fee in order to obtain publically financed services with good quality and quick access. More than 70% of respondents of ASSPRO CEE survey reported that in case they experience a major health problem would be willing to pay for a consultation and examination by a medical specialist (median value of stated payments was 50PLN) . For a hospital stay (a 5-day hospitalization due to planned surgery) half of the respondents stated their willingness to pay with the median value of payment 400PLN. Those not willing to pay are mostly both unable to pay and object to pay for public services. The previous research indicated that health care consumers in Poland are against introduction of formal obligatory fees for publicly financed health care services. One of the main reasons of consumer objections is poor quality and restricted access to public health care services which often compels them to seek health care in a private sector. Thus, the attitudes of the consumers towards the cost-sharing may change if adequate access and quality of services are assured.

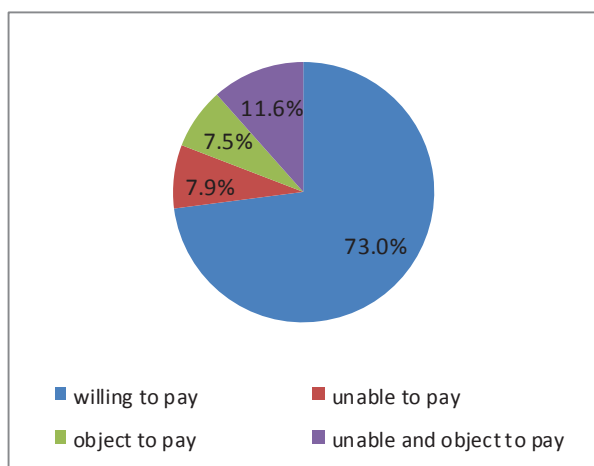


Fig.3. Willingness to pay for outpatient specialists' visits (percentage of respondents)

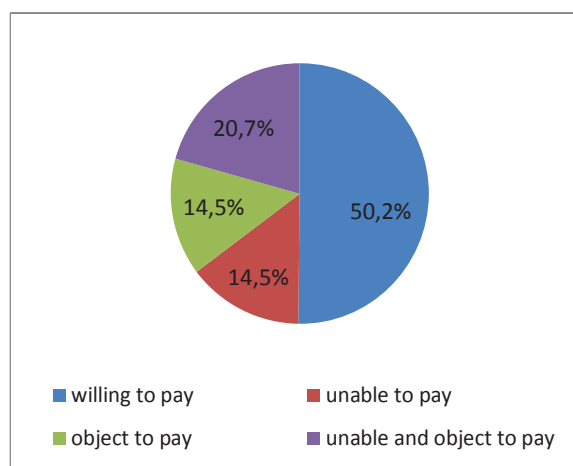


Fig.4. Willingness to pay for hospitalization (percentage of respondents)

Being willing to pay for health care services is associated with health status, consumer age, income, and residence place. Likewise paying formally for physician services, those who are younger are more likely to be willing to pay for health care services (for both outpatient specialists' care and hospitalization). The willingness to pay is also greater among those with higher income. They are able to pay for health care services but they may also have greater preferences for improved health care services. However, the willingness to pay is significantly lower for people with poor health. Since they are frequent health care users, they might recognize that accumulated shares impose a financial burden. The residence place is also related to the willingness to pay. Those who are living in a big city or town are statistically less willing to pay for health care than those living in a village. The higher willingness to pay among people living in rural areas may be rooted in the fact that for many decades of communist period the entitlement to free health care was restricted to certain population groups while farmers who were not entitled, were required to cover full or part of health services cost.

Main findings and recommendations

- In Poland during the last decade, despite the increase in the level of out of pocket expenditure, their share in total health expenditure declined due to substantial rise of public spending on health.
- In the structure of household out of pocket expenditure, spending on pharmaceuticals dominates ranging from about 50% to more than 80%. *Nota bene*, the recent amendments in the reimbursement law (entered into force in 2012), which introduced caps on public spending on pharmaceuticals may lead to an increase in private expenditure on drugs. Consequently, the space for private funding of services is still limited.
- Out of pocket expenditures are the highest among population groups with high health needs i.e. pensioners, suffering from chronic diseases (they pay mostly for pharmaceuticals) but also among individuals with higher income (they pay more often for services).
- The expenditure on services most often refers to paying for outpatient specialists' services, rehabilitation services and dental care. They are reported more often by younger people and those with higher income who rather pay for services in a private sector than co-pay for public services.
- Analysis of willingness to pay for health care services shows that Polish consumers do not object to co-pay for health services. Greater stated willingness to pay characterized younger people, those with higher income and better health status. The factor that influences willingness to pay by Polish consumers seems to be the possibility to obtain public services with good quality and quick access.
- Analysis of individual expenditure on health (both on pharmaceuticals and services) indicates that patient payments put a burden mostly on population groups with the highest health needs (elderly, disabled, suffering from chronic diseases) while their willingness to pay is the lowest. In this situation, the prospect for extending the scope of patient payments for the entire population in Poland appears to be distant. It would require applying mechanisms to protect the most vulnerable population groups against catastrophic health expenditure, which in turn would reduce the fiscal efficiency of the patient payment system
- Implementing measures to increase financial resources of the health sector, such as patient payments for health care services, requires greater public resources devoted to health to improve access and quality of health care services, which will also increase patient willingness to co-pay for public health services.

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