



World Health
Organization

REGIONAL OFFICE FOR Europe

Can people afford to pay for health care?

New evidence
on financial protection
in Poland

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Summary

WHO Barcelona Office for Health Systems Strengthening

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This review assesses the extent to which people in Poland experience financial hardship when they use health services, including medicines. The analysis draws on household budget survey data collected annually by the Central Statistical Office of Poland (Główny Urząd Statystyczny, GUS) between 2005 and 2014. It focuses on two indicators of financial protection: catastrophic health spending and impoverishing health spending. It also considers the presence of access barriers leading to unmet need for health care.

Spending on health

Research shows that financial hardship is more likely to occur when public spending on health is low in relation to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of current spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Poland spends less publicly on health than many other central and eastern European countries. In 2016, public spending on health accounted for 11% of government spending and 4.6% of GDP, which is among the lowest in the European Union (EU) (Fig. 1).

Fig. 1. Public spending on health and GDP per person in the EU, 2016

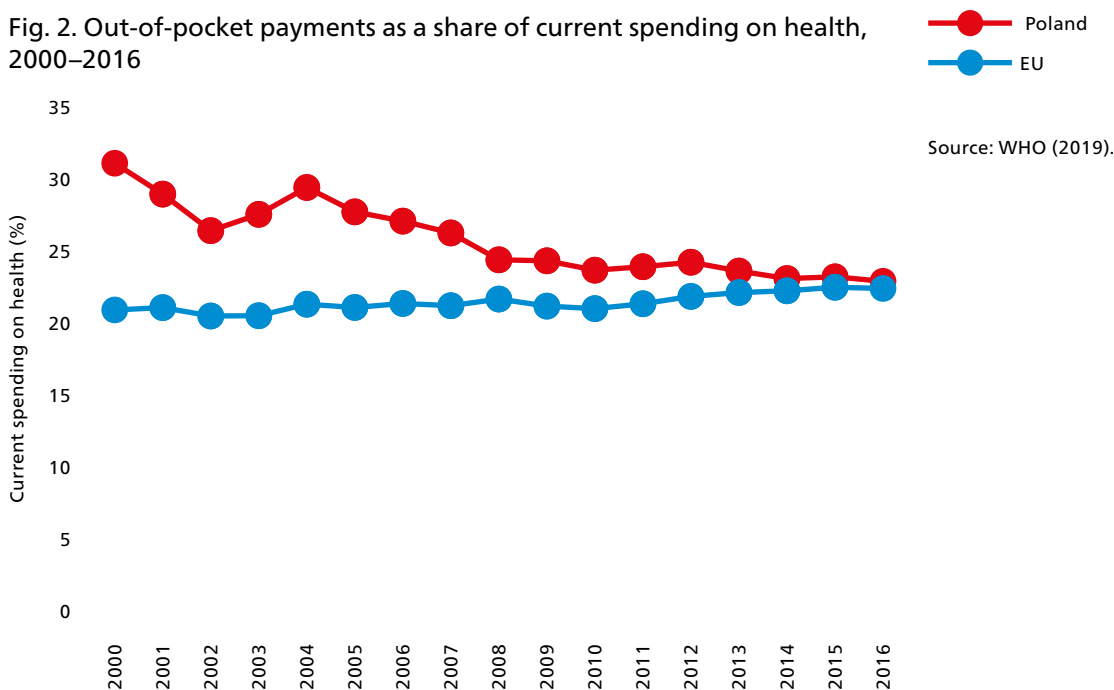
Notes: PPP: purchasing power parity. Public refers to all compulsory financing arrangements. The figure excludes Ireland and Luxembourg. Poland is highlighted in red.

Source: WHO (2018).



National Health Accounts data show that out-of-pocket spending per person increased in Poland between 2000 and 2015, but public spending increased at a faster pace, growing strongly between 2000 and 2008 (WHO, 2018). Growth in public spending on health per person prompted the out-of-pocket payment share of current spending on health to fall from 31% in 2000 to 24% in 2008 (Fig. 2).

Fig. 2. Out-of-pocket payments as a share of current spending on health, 2000–2016



Although Poland was relatively resilient to the financial and economic crisis, growth in public spending on health per person stopped between 2009 and 2012. This coincided with a halt in the steady decline in the out-of-pocket payment share of current spending on health. In 2016, out-of-pocket payments accounted for 23% of current spending on health, above the EU average of 22% (Fig. 2).

At the end of 2017, legislation was passed to increase public spending on health as a share of GDP to 6% by 2025.

Poland's National Health Fund (NHF) is responsible for purchasing all publicly financed health services. The NHF is financed predominantly through payroll taxes. It receives transfers from the government budget to cover the contributions of non-paying groups of people and provision of services for uninsured people, but these funds amount to only around 3% of the NHF's total revenue, while non-paying family members account for nearly a quarter of the insured population (Sagan et al., 2019). This heavy reliance on payroll taxes puts pressure on health system revenues and has in recent years led to discussion about the need to increase government budget transfers to the NHF.

Coverage, access and unmet need

Over 90% of the population is covered by the NHF, which provides free access to publicly financed primary care, outpatient specialist care, inpatient care and emergency care. Most of the remaining population are thought to be eligible for public coverage, although their status is not confirmed on the NHF register.

The main gaps in health coverage are related to:

- extensive user charges (co-payments) for outpatient medicines, including high percentage co-payments for many medicines, with limited protection mechanisms;
- extensive user charges for medical products, with reliance on percentage co-payments and low reimbursement limits, and without regulation of prices and quality, so actual costs may often exceed the reimbursement price;
- lack of waiting time guarantees for NHF-financed services;
- limited coverage of dental care, particularly for adults; and
- entitlement based on insurance status (with the exemption of primary care), meaning there are people not eligible to be covered by the NHF.

The design of user charges policy for outpatient medicines is particularly complex and mechanisms to protect people from user charges generally are weak. There are no exemptions explicitly benefiting poor households and people with chronic conditions and no cap on user charges paid. Protection for older people has been strengthened recently; since 2016 (after the study period), people aged over 75 years have been entitled to free access to the 150 molecules most commonly used by older people.

Issues with waiting times increasingly are leading people to use privately financed services. The main reasons people give for increased use of private health-care providers are shorter waiting times, better quality and, for dental care, lack of publicly financed coverage.

Voluntary health insurance (VHI) obtained from private insurance companies or, more commonly, through employment schemes (medical subscriptions) covers less than 10% of the population. It provides faster access to services in the private sector, mainly for ambulatory care. Survey data indicate that VHI take-up has increased over time but generally is limited to more affluent groups; VHI therefore is likely to exacerbate inequalities in access to health care.

Unmet need for health care due to cost, distance or waiting time was substantially higher in Poland than the EU average in 2016, while unmet need for dental care was similar to the EU average (Fig.3). Unmet need for health care mainly is driven by waiting time, and unmet need for dental care by cost. Unmet need for prescribed medicines due to cost is higher in Poland than in the EU, particularly for older people (Eurostat, 2018). National data suggest that paying for prescribed medicines constituted a significant financial burden for 34% of households in 2016, with a further 7% unable to afford prescribed medicines (GUS, 2018).

Socioeconomic inequalities in unmet need for health care, dental care and prescribed medicines are substantial, although they have narrowed slightly in recent years for health care and dental care (Eurostat, 2018).

Fig. 3. Self-reported unmet need for health care and dental care due to cost, distance and waiting time

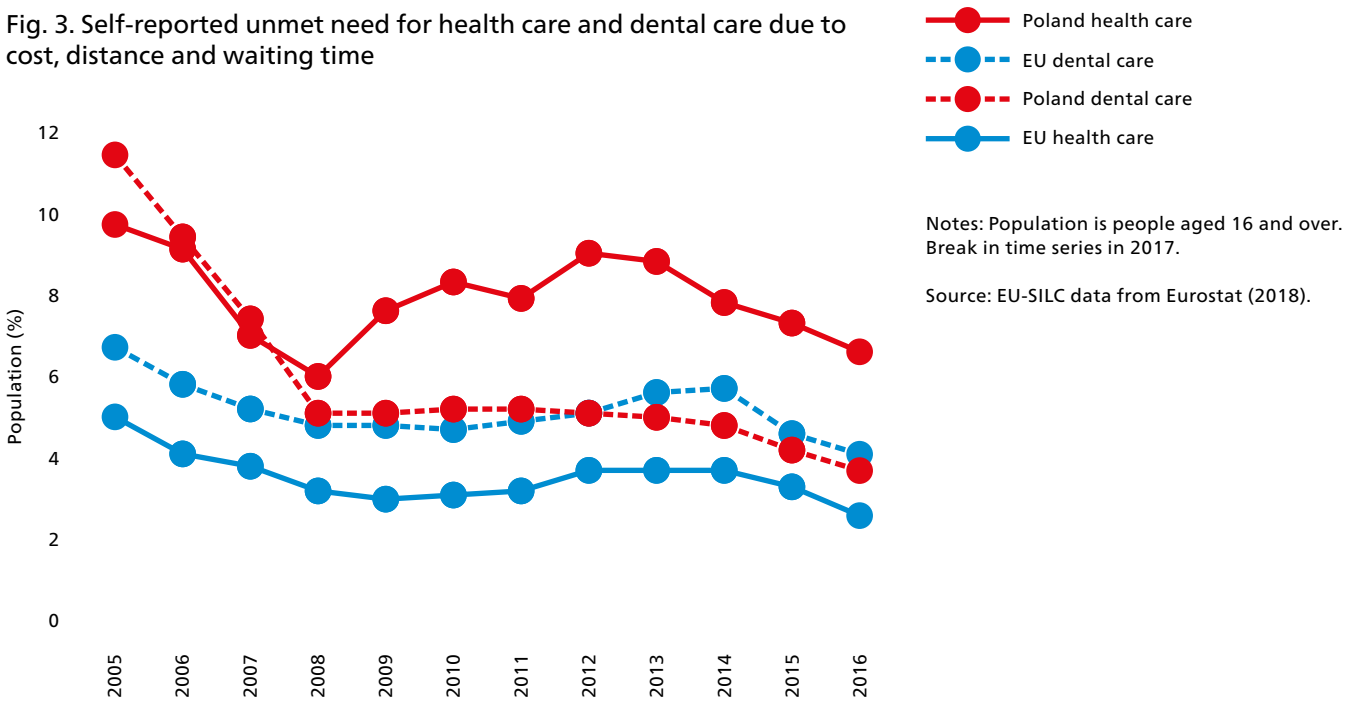


Table 1. Gaps in coverage

Source: authors.

	Population entitlement	The benefits package	User charges (co-payments)
Issues in the governance of publicly financed coverage	Entitlement is based on citizenship and insurance status Although dependent family members are covered without having to pay contributions, the government does not pay contributions on their behalf	Limits on the volume of services contracted by the NHF and lack of waiting time guarantees	Use of percentage co-payments for outpatient medicines and medical products, with limited exemptions and no caps The reimbursement and pricing of medical products is poorly regulated
Main gaps in publicly financed coverage	Nine per cent of the population is uninsured; in practice many of these people may be eligible for coverage retroactively or working abroad	Waiting times for specialist care The range of dental care services is very limited for adults	Outpatient medicines and medical products Long-term care institutions and spa treatment
Are these gaps covered by VHI?	No	VHI provides faster access, mainly to outpatient care; however, it covers less than 10% of the population, usually higher-income households	No

Household spending on health

Household budget survey data indicate that out-of-pocket payments accounted for 5.2% of total household spending in 2014. This is higher than in many central and eastern European countries, such as Estonia (4.3%), Croatia (3%), Czechia (2.7%) and Slovenia (2.2%).

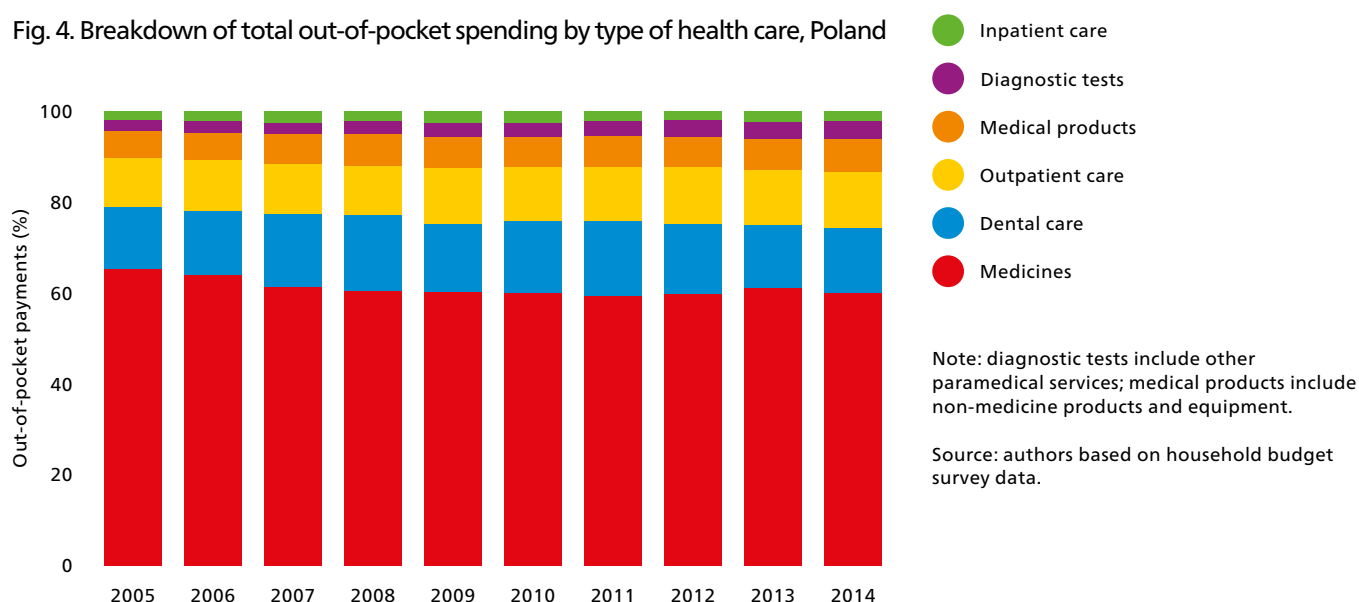
Although on average out-of-pocket payments remained fairly stable over time as a share of total household spending, they increased in nominal terms from PLN 417 per person in 2005 to PLN 647 in 2014.

Between 2005 and 2014, the largest increase in out-of-pocket payments in nominal terms was among the poorest quintile, which experienced average annual growth of 8%, pushing up the share of the household budget spent on health in this quintile from 3.5% to 4.1% and narrowing the gap in spending between the richest and poorest quintiles. Households in the richest quintile nevertheless spent about six times more out of pocket on health in 2014 than those in the poorest.

Medicines account for the largest share of out-of-pocket payments: around 60% on average (Fig. 4), but over 75% in 2014 in the poorest quintile (data not shown). The share spent on medicines has decreased over time for all except the poorest quintile. The second and third largest spending areas are dental care (about 13–17%) and outpatient care (11–12%) (Fig. 4). In nominal terms, out-of-pocket payments for all types of services increased during the study period.

Evidence suggests that informal payments are an issue in Poland, particularly in inpatient care, but on a smaller scale than in many other central and eastern European countries (Stepurko et al., 2013; Czapiński & Panek, 2015; European Commission, 2017).

Fig. 4. Breakdown of total out-of-pocket spending by type of health care, Poland

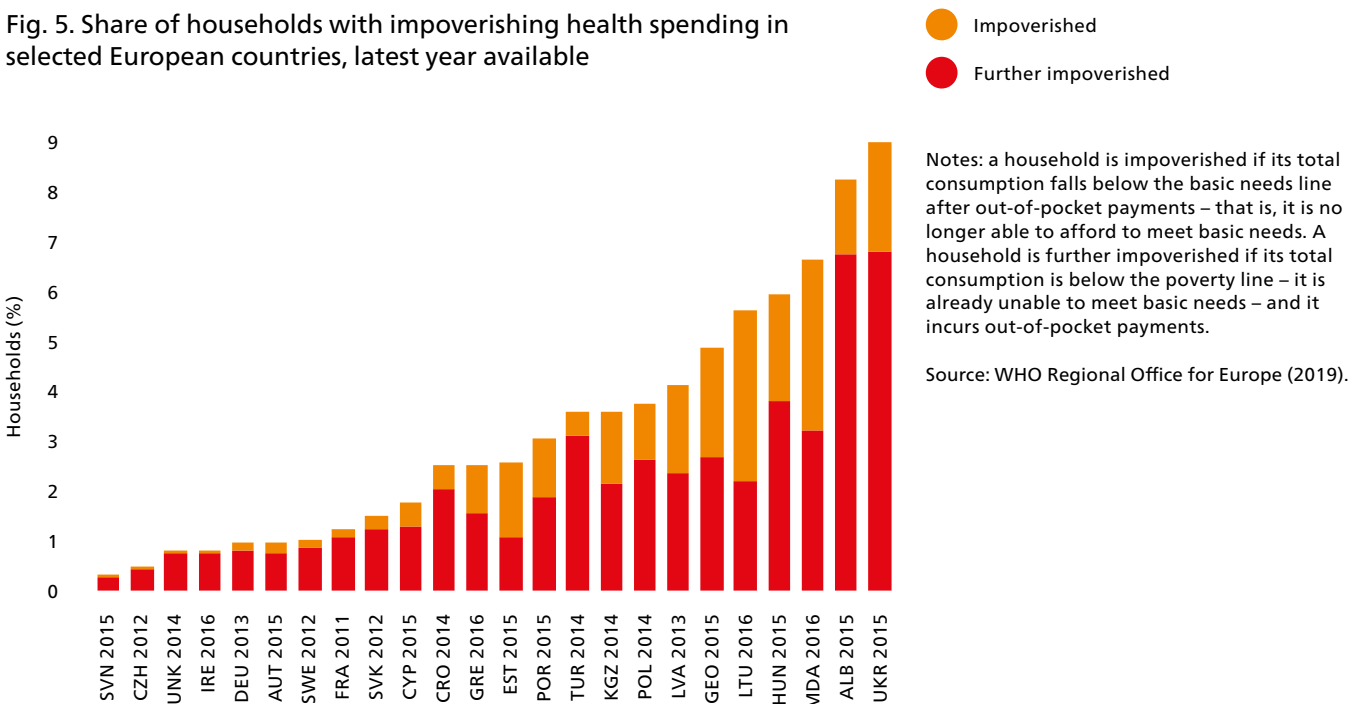


Financial protection

Financial protection is fairly weak in Poland compared to many EU countries, including some countries in central and eastern Europe (WHO Regional Office for Europe, 2019).

In 2014, 3.8% of households experienced impoverishing health spending in Poland, which was higher than in many other EU countries but lower than in Hungary and Lithuania (Fig. 5).

Fig. 5. Share of households with impoverishing health spending in selected European countries, latest year available

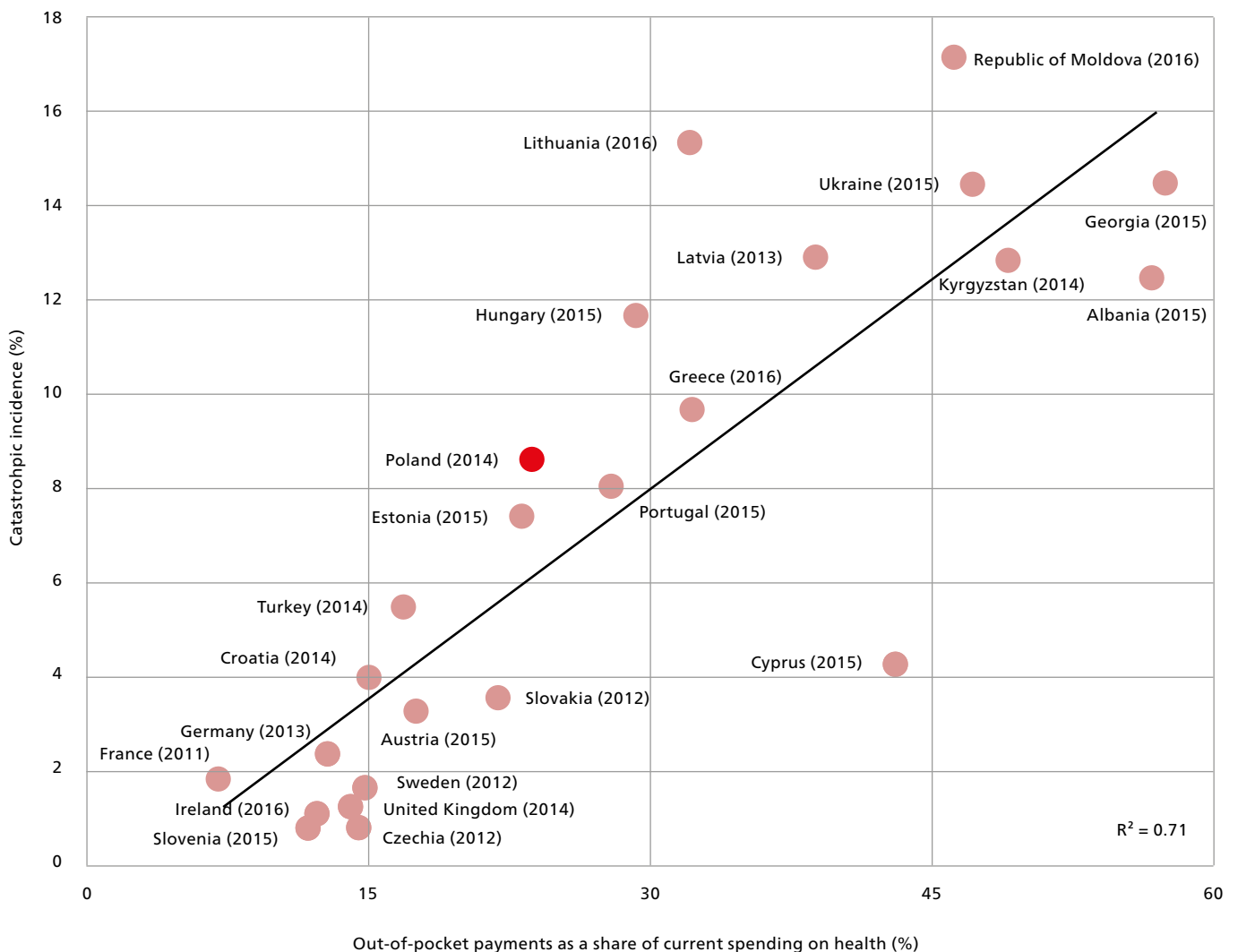


One in 12 households in Poland (8.6%, or 3.7 million people) experienced catastrophic health spending in 2014 (Fig. 6). Catastrophic spending is heavily concentrated among the poorest consumption quintile (Fig. 7). Across the study period, two thirds of households with catastrophic spending were further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 8). Households receiving social benefits are the group with the highest incidence of catastrophic spending, followed by households receiving disability or survivor's pensions, large households, retirees and people living in rural areas.

Fig. 6. Incidence of catastrophic health spending and out-of-pocket payments as a share of current spending on health in selected European countries, latest year available

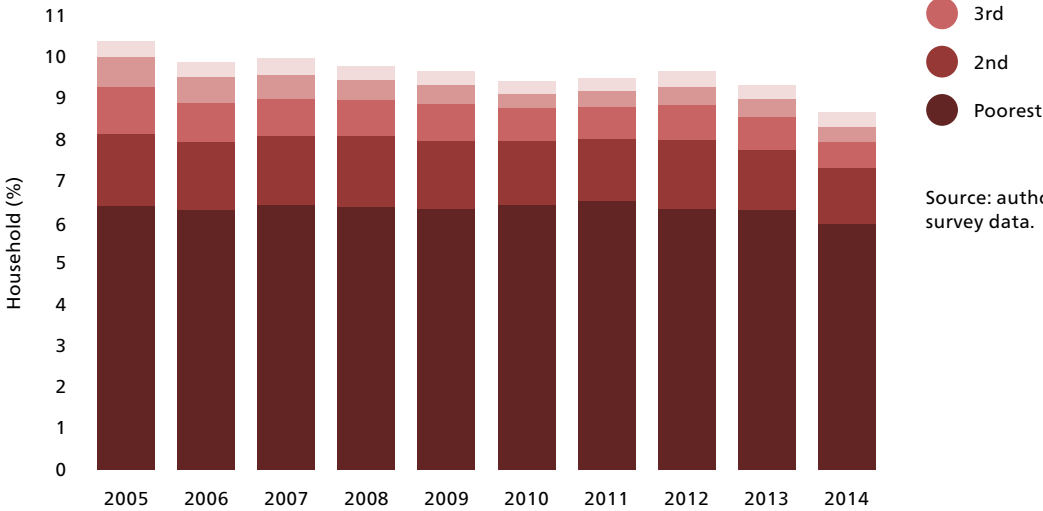
Notes: R²: coefficient of determination. The out-of-pocket payment data are for the same year as the catastrophic spending data. Poland is highlighted in red.

Source: WHO Regional Office for Europe (2019).



Although financial protection improved between 2005 and 2014, the improvement was largely driven by a reduction in catastrophic incidence in non-poor households, especially in the third and fourth quintiles. The incidence of catastrophic spending in the poorest quintile fell only marginally over time, from 32% in 2005 to 30% in 2014.

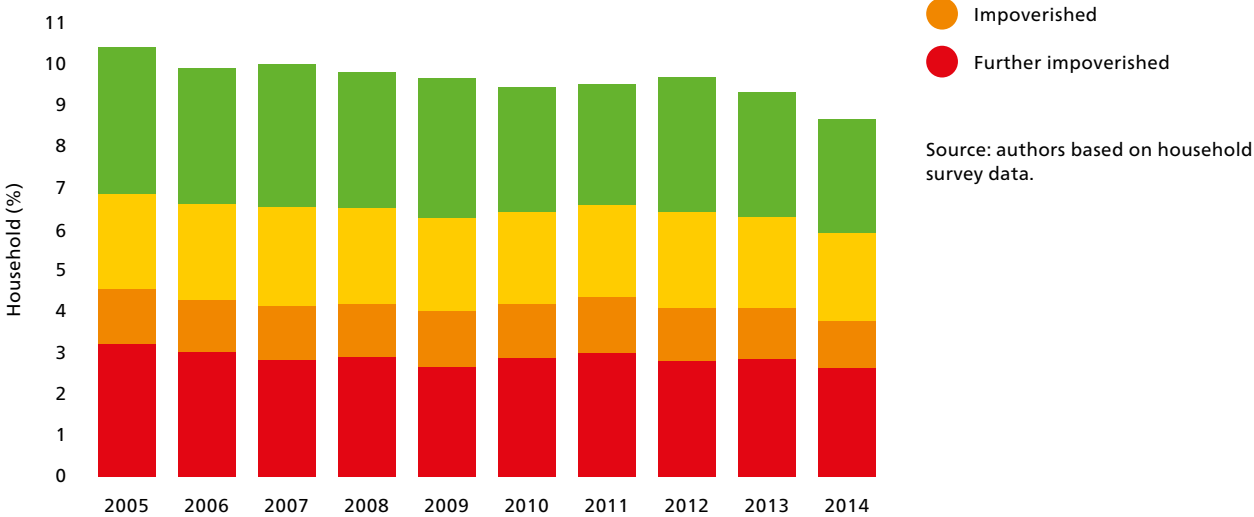
Fig. 7. Share of households with catastrophic health spending by consumption quintile, Poland



- Richest
- 4th
- 3rd
- 2nd
- Poorest

Source: authors based on household budget survey data.

Fig. 8. Share of households with catastrophic health spending by risk of impoverishment, Poland

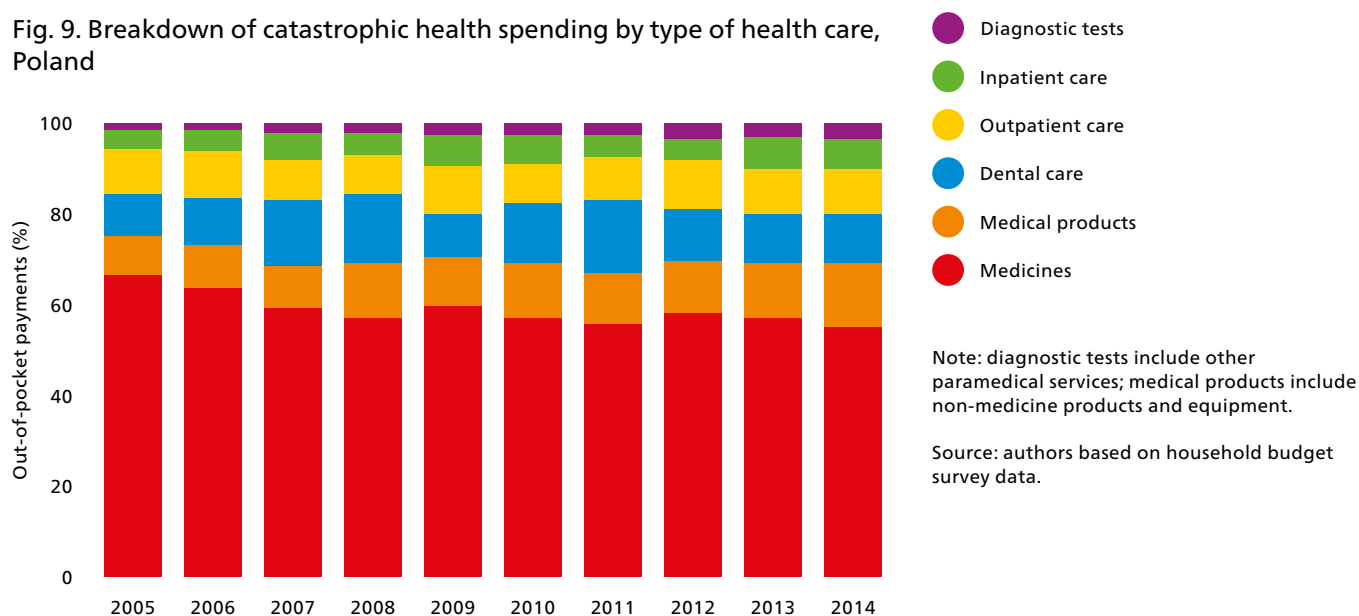


- Not at risk of impoverishment
- At risk of impoverishment
- Impoverished
- Further impoverished

Source: authors based on household budget survey data.

Medicines consistently account for the largest share of out-of-pocket catastrophic spending (55% in 2014), followed by medical products (14%), dental care (11%) and outpatient care (10%) (Fig. 9). The medicines share decreased during the study period overall but remained high (over 75%) in the poorest quintile (data not shown). The change in composition came only as households in the richer quintiles began to spend more on other types of services, in addition to medicines.

Fig. 9. Breakdown of catastrophic health spending by type of health care, Poland



Factors that strengthen and undermine financial protection

Health coverage is relatively comprehensive for those insured by the NHF, but several aspects of coverage policy are likely to undermine financial protection.

- Although primary and specialist care and diagnostic tests are free at the point of use, there is a complex system of heavy user charges for outpatient-prescribed medicines. No exemptions explicitly benefiting low-income people or people with chronic conditions are in place, and there are no caps on user charges.
- There are no waiting time guarantees. Waiting times are an issue, particularly for specialist care, leading some households to use privately financed services. While VHI provides faster access and access to private providers, take-up of VHI favours better-off groups of people.
- Problems in accessing outpatient services may lead people to self-treat using over-the-counter medicines, again shifting costs onto households. The use of non-prescribed medicines is very high (Eurostat, 2018), with non-prescribed medicines accounting for over three quarters of all out-of-pocket spending on medicines (OECD, 2017).
- Coverage of dental care is limited, especially for adults, with no protection for low-income households. Richer households are more likely to be able to afford privately financed dental services.

- Coverage of medical products is also limited, especially for adults. Heavy user charges for some products, stringent limits to NHF coverage and weak market regulation combine to shift the costs of medical products onto households.
- National statistics indicate that about 9% of the population is not covered by the NHF. Although this share is likely to be an overestimate, some people may experience financial barriers to access and financial hardship due to not being insured.

These gaps in coverage are compounded by the fact that government budget transfers to the NHF to cover the costs of uninsured people and the contributions of selected population groups only amount to 2–3% of NHF revenue, and there are no government budget transfers to cover contributions for dependants, even though they account for 23% of the people insured by the NHF.

The improvement in financial protection seen in the middle quintiles over time cannot be explained by changes in coverage during the study period. They are more likely to reflect changes in living standards. Unmet need for health care increased after the crisis and, while out-of-pocket payments continued to increase, they did so at a much slower rate than before the crisis.

Recent initiatives inside and outside the health sector are likely to have improved financial protection for some groups of people in the years after the study period. The Family 500+ programme initiated in 2016 provides additional income support for all families with two or more children and low-income families with children. People aged 75 years and over have been exempt from co-payments for many prescribed medicines since 2016. From 2017, primary care (excluding prescribed medicines) has been free at the point of use for the whole population, regardless of insurance status.

Implications for policy

Financial hardship linked to out-of-pocket payments is high in Poland compared to many other EU countries. It is heavily concentrated among the poorest households. Households receiving social benefits are the group with the highest incidence of catastrophic health spending, followed by households receiving disability or survivor's pensions.

Financial protection has improved over time, but this has been driven largely by a reduction in catastrophic incidence in non-poor households, and probably reflects broader economic conditions. Poland was relatively resilient to the financial crisis; wages, pensions and public spending on health continued to rise after 2008. The rate of growth in public spending on health slowed significantly during and after the crisis, however, pushing up the out-of-pocket share of current spending on health. The extreme poverty rate and income inequalities in pensions also increased following the crisis, which may explain why improvements in financial protection over time were mainly experienced by households in the richer quintiles.

Outpatient medicines are the largest single driver of catastrophic health spending across all consumption quintiles except the richest. Medicines consistently account for nearly two thirds of all catastrophic spending, rising to 75% in the poorest quintile. At the same time, there are high levels of self-reported unmet need for prescribed medicines due to cost, especially among households with lower socioeconomic status.

Policy attention should focus on improving the affordability of outpatient medicines. Limitations in the currently complex design of user charges for outpatient-prescribed medicines should be addressed. For example, fixed co-payments could be extended to a much larger share of medicines, reducing or even eliminating the use of percentage co-payments; there are no exemptions explicitly benefiting poor households and people with chronic conditions; and there is no cap on co-payments. High levels of use of, and out-of-pocket spending on, non-prescribed medicines also warrant attention. There is a need to strengthen regulation of the market for over-the-counter medicines, including rules around advertising, and for public awareness campaigns to reduce use.

Waiting times may present an increasing barrier to access to specialist care, driving catastrophic spending on outpatient care for all quintiles and catastrophic spending on inpatient care for the richest quintile. This suggests that NHF-financed specialist services are not always accessible, prompting patients to seek privately financed care or self-treatment through use of over-the-counter medicines. VHI does not help, as it mainly covers higher-income households.

Medical products and dental care are now the second and third largest drivers of catastrophic health spending, but mainly among richer households, in line with evidence of substantial inequalities in unmet need for dental care due to cost. Improving the NHF's coverage of dental care – by, for example, introducing enhanced entitlement for poor households – would reduce both unmet need and financial hardship. For medical products, the effects of coverage and volume limits are exacerbated by weak market regulation leading to high prices. Proposals to align the coverage of medical products with HTA principles could contribute to improved quality and more efficient use of resources. These measures alone, however, are unlikely to improve access or reduce financial hardship, as the experience of prescribed medicines shows.

It is important to focus attention on the equity implications of financial hardship and of ongoing efforts to improve financial protection. During the study period, the poorest households experienced the steepest increase in out-of-pocket spending on health, particularly in the years before the crisis. As a result, they experienced the smallest decrease in catastrophic spending, and catastrophic incidence actually increased substantially for people receiving social benefits – the group with the highest risk of catastrophic spending after the poorest quintile as a whole. People receiving social benefits are also the only group for whom catastrophic incidence was higher in 2014 (18.2%) than in 2005 (15.7%).

Future efforts to improve financial protection should focus more on low-income households, including people receiving social benefits, building on recent steps to improve living conditions for large families and

enhance financial protection for people aged over 75 years. Mechanisms to protect households from co-payments are generally weak and do not explicitly benefit low-income households. New programmes exempting people aged over 75 years from co-payments for many medicines and the Family 500+ programme to support families with children have the potential to improve financial protection among older people and families with children. These initiatives are welcome steps forward, but other low-income groups, such as recipients of social benefits and disability pensions, are at most risk of catastrophic health spending; these groups therefore would benefit significantly from exemption from co-payments for medicines and medical products.

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Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household's resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household's resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on consumption expenditure or income and may not fully capture all of a household's financial resources—for example, savings and investments.

Basic needs: The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

Basic needs line: A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

Budget: See household budget.

Cap on benefits: A mechanism to protect third party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

Cap on user charges (co-payments): A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person's income. Sometimes referred to as an out of pocket maximum or ceiling.

Capacity to pay for health care: In this study capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

Catastrophic out-of-pocket payments: Also referred to as catastrophic spending on health. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household's capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished (because they no longer have any capacity to pay after incurring out-of-pocket payments) and households who are further impoverished (because they have no capacity to pay from the outset).

Consumption: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but procured for consumption in other ways (for example, home-grown produce).

Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. Fixed co-payments are a flat amount per good or service; percentage co-payments (also referred to as co-insurance) require the user to pay a share of the good or service price; deductibles require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include extra billing (a system in which providers are allowed to charge patients more than the price or tariff determined by the third party payer) and reference pricing (a system in which people are required to pay any difference between the price or tariff determined by the third party payer – the reference price – and the retail price).

Equivalent adult: To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

Exemption from user charges (co-payments): A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

Financial hardship: People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

Financial protection: The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.

Further impoverishing out-of-pocket payments: An indicator of financial protection. Out-of-pocket payments made by households living below a national or international poverty line or a basic needs line. A household is further impoverished if its total consumption is below the line before out-of-pocket payments and if it incurs out-of-pocket payments.

Health services: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during

a given period and the imputed value of items that are not purchased but procured for consumption in other ways.

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

Impoverishing out-of-pocket payments: An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

Out-of-pocket payments: Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: (a) formal co-payments (user charges or user fees) for covered goods and services; (b) formal payments for the private purchase of goods and services; and (c) informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

Poverty line: A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.

Quintile: One of five equal groups (fifths) of a population. This study commonly divides the population into quintiles based on household consumption; the first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.

Risk of impoverishment after out-of-pocket payments: After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

Universal health coverage: All people are able to use the quality health services they need without experiencing financial hardship.

Unmet need for health care: An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

User charges: Also referred to as user fees. See co-payments.

Utilities: Water, electricity and fuels used for cooking and heating.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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