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Private Health Insurance as a Financing Source of Occupational Medicine (OM) in Poland: Opportunities and Dilemmas

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Abstract

The article raises a question of covering occupational health services (OHS) by private health insurance. Such an idea has been recently promoted in Poland in order to diversify financing sources and strengthen market forces in relation to occupational medicine (OM). However, its implementation in a long-existing, highly regulated and comprehensive Polish OM system (characterized in a synthetic way by the Authors from the legal, organizational and macroeconomic points of view) brings about several issues to discuss and solve, including a scope of OHS insurance, the relations between private insurers and OHS providers, exchange of information, obligations of employers. Therefore, introduction of OHS insurance products requires adopting legal regulations concerning the definition of OM/OHS as well as the detailed range of insurance coverage (types of risks and benefits covered under standard and extended policies, such as preventive medical examinations, workplace health promotion programs, health care services provided in case of accidents and occupational diseases, etc.). Lack of precise regulations in this area may potentially result in certain unintended and negative consequences, including a significant and uncontrolled growth of OHS costs, applying different (unequal?) protection standards for employees working in the same sectors/ branches/ workplaces and the so-called "cream skimming" phenomenon limiting health insurance scope to the most financially effective insurance "products". Finally it should be emphasized that successful implementation of OHS private insurance policies requires introducing fiscal incentives (tax reliefs for employers on OM insurance costs). Otherwise employers will be more likely to purchase OHS in the old ways - from medical firms (OHS as the core element of "medical packages") or directly from OHS providers.

Keywords: Occupational health services; Occupational medicine; Insurance; Tax reliefs

Introduction

Poland - Middle - size country in Central Europe and a Member State of European Union (from 2004) - has a long tradition of occupational medicine which has been developing since the end of World War II, under the communist rule. In this period the importance of Occupational Medicine (OM) was specially stressed for ideological reasons - the so called "working class" was proclaimed the leading force of the society so solicitude for its health became a political priority. The beginning of the transformation period from a planned to a market economy (after the political changes in 1989) raised the issue of assessing and redesigning previous arrangements.

Consequences of Poor work Conditions in Numbers

The need for occupational medicine is obvious. Poor work conditions have direct impact on deteriorating the population`s health (including number of accidents, fatal cases, number of occupational diseases, morbidity and mortality due to these diseases, etc.) as well as on economic situation at both micro and macro levels (absence of workers, direct costs borne by employers, productivity losses, burden on health and social care systems, etc.). The recent health statistics for Poland (2010) [1,2] show:

Accidents at work (overall number of persons affected) - 94 207,

- Overall number of fatal cases - 444 (mainly in building and trade sectors, health and social care),
- Overall number of absence days - 3 429 527,
- Number of occupational diseases (new cases) - 3146 (infectious/ parasitic diseases, chronic disorders due to vocal abuse, silicosis among the most frequent occupational diseases).

The total burden on the country`s economy due to the above consequences is estimated at least 1% of GDP [3].

According to the Central Statistical Office in 2011 the total number of employed persons (i.e. economically active on labour market) in Poland was ~ 17, 8 million (50.7% employment rate) [4]. In 2010 the overall number of active enterprises overcame 1, 7 millions (a vast majority of them in private sector). Microenterprises (employing up to 9 persons) and small business (hiring from 10 to 49 persons) dominated by making together ~99% of the total number of enterprises (96% and 3% respectively), the share of medium business (from 50 up to 249) was less than 1% and big enterprises (with more than 250 employees) - only 0.1 – 0.2% [5]. The total number of registered economic entities was much higher (reaching almost 4 million), but many microenterprises, especially in form of individual economic activity (self-employment), fail to continue. The structure of enterprises in Poland differs from the EU-27 average where more microenterprises survive and tend to expand so small business is more developed (~7% average share of all enterprises). In order to complete the overall picture of economic activity in Poland it has to be mentioned that there were also ~2, 6 millions of individual farmers and members of their families/co-workers [6]. The above data illustrate in a synthetic way the potential demand side for the occupational medicine in Poland.

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Legal Regulations of Occupational Health Services (OHS) in Poland

The legal framework of OHS consists of several acts, such as: the Act on Occupational Health Service, the Labor Code Act, the Act on Health Care Activity, the Act on Public Finances [6-9].

OHS also has its references to the legal regulations concerning state budget, local authorities and taxes. The above short enumeration of legal framework in regard to OHS shows its connection to a number of issues concerning national economy as a whole, the role of state, public finances, employers, and healthcare sector, including public insurer (National Health Fund), private insurance companies, and public and private health providers. They deal with financial system (financing sources and flows), legal and organizational forms of OHS as well as the OM relations to other sectors and institutions.

Employers (companies and institutions) are obliged to purchase occupational healthcare services (OHS) for their employees being the direct customers of OHS providers.

Main Types of Occupational Health Services (OHS)

OHS include obligatory pre-employment medical examinations for all employees as well as their periodical medical checking during employment time. The scope of examinations depends on risk factors connected with particular types of working posts and conditions including several medical tests, different outpatient specialist consultations, and finally - issuing statements of capability for work by OM physicians. About 4, 6 million of such statements (pre-employment, control, periodical) are issued yearly [10]. The largest part of them is periodical examinations, number of which overcomes 2, 2 million per year.

The OM consists also of a wide range of other activities:

- preventive care due to working conditions,
- curative/occupational rehabilitation,
- emergency services (so called “first aid”) at work,
- vaccinations,
- health promotion programs,
- health care reviews and analyses,
- assessment of occupational risks, collecting data, periodical reviews/audit.

Occupational Medicine at the Country Level-Institutions, Resources, Customers, Financing

Many healthcare entities – both public and private – are involved in OM provision. Looking from macro perspective three levels of OM providers can be distinguished as follows:

- central level with OM scientific research institutes and OM clinics in medical universities, among them Nofer Institute of Occupational Medicine in Lodz, Institute of Occupational Medicine and Environmental Health in Sosnowiec, Central Institute for Labour Protection – National Research Institute in Warsaw, Institute of Rural Health in Lublin, and others,
- regional level consisting of 20 Regional Occupational Medicine Centers (ROMC),
- basic/primary level with 7029 OM providers/units.

Scientific institutions as well as regional providers are mainly public while the majority of basic providers are non-public.

According to the Act on Occupational Health Service primary occupational health services units operate as outpatient healthcare clinics in organizational form of:

- entire health care entities established and operating with the aim to provide preventive medical care to employees,
- parts of health care entities devoted to provide preventive health care to employees,
- physicians - specialists in occupational medicine running medical practices (individual or group)
- regional centers of occupational health.

In the ownership structure of the basic providers individual physician practices (33.36 – 47.46%) and private health care entities (28.85 – 41.06%) predominate [11]. Together with a small share of group physician practices private sector reaches 88.82% share in the total number of basic OM units. 790 (11.2%) of the basic providers remain public functioning as the so called autonomous public health care institutions with a substantial extent of autonomy over financing and management. Most of them are medium-size out-patient clinics offering a variety of occupational health services (OHS).

There is some confusion about clear division of work and responsibilities regarding OM between the above distinguished levels. Regional Centers which leading statutory task is defined as supervising occupational health services often provide OHS themselves so they partially function as basic units. Performing preventive examinations (obligatory activity of OM primary units) Regional Centers are paid for OHS provided. Thus they supervise basic units and at the same time compete with them for OHS contracts.

OHS in Poland is financed from multiple sources although the main financial burden is laid on employers and self-employed persons (individual payments). Employers buy OH services in the form of contracts with OHS units or as a part of the so called pre-paid “medical packages” which may be extended on other health services (not only OHS) creating social benefits packet for employees. The “medical packages” are offered by private firms, creating nets of basic providers. This market has been developing since the beginning of transformation period (1989) [12].

The other financing sources of OM include:

- state budget (scientific institutes and medical universities),
- local authorities` budgets (regional level),
- social health insurance institutions (National Health Fund, social insurance for workers and farmers).

The Proposal of Developing Private OM Health Insurance as Additional Source of OHS Financing - Opportunities vs. Dilemmas

In the long-term strategy of shaping the entire health system Polish Ministry of Health stresses the growing role of private sources of financing and private providers. For the last few years MoH is actively involved in preparing a draft of private additional/supplementary health insurance act and its submission for further legal proceeding [13].

According to the proposal OHS can be offered by private health insurance companies as a new "product". OHS premiums should be set separately from other services covered by private health policies. This way employers as well as self-employed persons will be given a choice between direct contracting OHS with OM providers or purchasing OM policies in private insurance sector.

This general idea is very much disputable having its proponents and opponents. For the great part of analysts the idea of OM insurance policies needs further developments in terms of both - its conceptual basis as well as operational details in many aspects.

The rational approach should start with clarifying the meaning of OM or OHS as a market "product" sold also by insurance firms. Is it going to be aggregated or fragmented? OM includes a range of services and cannot be limited to preventive medical examinations only. To what extent OM private insurance should function as an integrated protection against health risk at work? Does it have to cover also occupational diseases and accidents, which of them, etc.

OM experts are afraid of an uncontrolled expansion of OHS insurance "products" market which may lead to undesired consequences [14], such as:

- Possibility of insuring different employees from the same workplace by more than one insurance company,
- Raising cost of OM for employers,
- Diffusion of responsibility for OM between too many competing market players,
- "Cream skimming", i.e. offering the most financially effective OHS "products" by health insurance, while leaving the most difficult and costly not addressed [15].

There is a number of issues which need legal, structural, managerial solutions and first of all - co-ordination. One of them is an access to data resources on occupational health state and risks. According to the present regulations and practice basic OHS units are the "owners" of overall information on occupational safety and health in companies. Exchange information on work environment between basic OM units and employers and/or insurers has not become yet a subject of new regulations. Under the current legislation OHS units are obliged to co-operate with employers in regard to proper forms of health protection at work and health programs adapted to the type of work and risk conditions. Also workplace inspections have to be done by OHS physicians. The above raised questions were used as examples to point out many specific problems concerning OM with wide involvement of insurance sector. Are OHS insurance policies going to cope effectively with the problems? If not, or partially, who and how should perform the remaining tasks? From what sources and how to pay for them?

For obvious reasons, insurance sector is strongly supporting the idea of promoting and creating special legal basis for OM insurance. For medical firms offering OM as a part of "medical packages" new proposals mean much stronger competition. For basic OHS providers the role of new "third party" players of insurance sector it is still not clear enough what factors overcome - opportunities or threats?

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