



What is the future of private health insurance in Poland?

Pharma Poland News talks to Dr Krzysztof Łanda, CEO of Meritum L.A., founder of Watch Health Care Foundation and co-author and editor of a new book on health insurance and benefits packages (“Ubezpieczenia zdrowotne a koszyk świadczeń”, published by CEESTAHC in November 2011) about the functioning of the guaranteed healthcare benefits package and the future of private health insurance in Poland.

Monika Stefańczyk, *Pharma Poland News*: When the Ministry of Health enacted first regulations on the guaranteed healthcare benefits package in 2009, they were met with certain criticism, particularly from insurance firms. (The argument was that the package was so broad as to leave no scope for voluntary additional insurance). What is your opinion about the guaranteed benefits law adopted in Poland?

Krzysztof Łanda: There is no doubt that the so-called “guaranteed package act” of 2009 represented a milestone for the development of additional health insurance in Poland. Prior to its enactment, the scope of healthcare benefits guaranteed by the state was open-ended, meaning that theoretically everybody was entitled to everything. Now, by contrast, there is a close-ended list of benefits, quite well defined in executive regulations, whose scope has been narrowed compared with the previous situation. This represented the first step towards rationalising the scope of guaranteed healthcare benefits. The idea that everybody should have the right to everything makes no sense, since a government could theoretically spend its entire budget on healthcare services only. The late Prof. Zbigniew Religa used to say that we should treat all diseases, but not with all available methods. This is especially true in Poland, where mandatory healthcare premiums are relatively low, which means we cannot afford to pay for the very expensive and not cost-effective medical technologies.

The guaranteed package act has put an effective end to endless debates about the need, or otherwise, to “create” a guaranteed benefits package. Instead, discussions now focus on what the various parts of the package should look like and how their functioning could be improved within the healthcare system. To be sure, the current management of the benefits package is far from perfect and we

definitely have a lot to learn from more developed countries, such as e.g. the Netherlands, Canada, Great Britain, or Australia.

My generally positive view of the impact of the guaranteed benefits package act is qualified, however, by my highly critical assessment of the functioning of the list of reimbursed medicines – an important part of the package – which is disastrous in Poland. In fact, it is worse now than at any time that I can remember.

Should the National Health Fund (NFZ) be made to compete with private insurance firms acting as rival payers, in your view?

I am opposed to the idea of the NFZ being subjected to competition in collecting mandatory fees and paying for the costs of guaranteed healthcare benefits. What I am advocating is that the scope of the guaranteed benefits package be curtailed, because in its current form it exceeds the financial means of the mandatory healthcare contribution system. A break-up of the NFZ would merely push up administration costs, while the emergence of private payers would further restrict access to healthcare benefits. So a more fruitful approach would be to work at improving the basic package so that it is proportionate to contributions and does not produce waiting lists.

Private health insurance, on the other hand, has an important role to play mainly in areas not covered by the guaranteed benefits package, which are currently in Poland relatively broad and growing. According to my estimates, there are at least 150 or 200 innovative drug technologies and some 1,000-2,000 non-drug technologies outside the basic package, which translates into a market worth PLN 15-30bn (€3.6-7.2bn) a year. We already have detailed calculations for the first complementary health insurance policies in Poland.

You mentioned waiting lists. Which healthcare benefits in Poland have the longest waiting lists? Which are the most readily available for patients?

Such information can be found on the website of Watch Health Care Foundation (www.watchhealthcare.eu, www.korektorzdrowia.pl). In the second half of February we will also launch a special WHC barometer, to be updated every four months, that will track waiting lists for five „reference” benefits, as indicators of access in each medical specialty, showing how the NFZ and the Ministry of Health are doing with the management of the guaranteed benefits package and with balancing the system. Our ranking lists are based on reports from patients, doctors, nurses, on data actively retrieved by WHC staff, but also on reports from NFZ officials themselves. The reports are anonymous and all calls are verified before ranking.

What, then, are the prospects for the private health insurance market in Poland, in 2012 and beyond?

At the moment the Polish market for voluntary health insurance is very small, estimated at PLN 1.5-2.5bn (€360-600m), and limited exclusively to supplementary insurance, i.e. policies whose coverage embraces some of health services from the guaranteed benefits package. Supplementary insurance feeds on the weaknesses of the public system and on growing waiting lists. As such, it represents insurance against the pathologies of the public healthcare system. My view, however, is that what we need in Poland is a completely different type of private insurance, namely complementary health insurance, which pays for benefits from outside the guaranteed package. Such insurance products have yet to emerge in Poland, but the guaranteed benefits act has made a first step towards their appearance.

The Reimbursement Act was no doubt meant to improve the functioning of that part of the benefits package that pertains to drug reimbursement: it established transparent criteria for drug assessment and laid down new standards for analysis and decision-making, for example. Unfortunately, its dreadful implementation could lead to increased costs for patients, even though drug prices have been reduced by an average of 8.5%, which in turn should be used to pay for new technologies. What I find particularly outrageous is the hasty addition to the announcement of updated lists of reimbursed medicines of 29 December 2011 of

a provision banning the reimbursement of soft-label uses (legally off-label but with fair evidence on efficacy). In this way numerous uses that are well-established in global medical practice, thoroughly tested, supported by multiple meta-analyses, randomised trials or systematic reviews, and whose effectiveness is questioned by nobody, have been shut out of the reimbursement system overnight by means of a legal document of the lowest possible status. A lot of technologies, often by no means the most expensive ones and with many generic equivalents, have been thrown out of the guaranteed benefits package without any advance notice, without expert opinion or any form of public consultation! In this way tens of thousands of people were put at risk to health or even to life itself. I find it to be a much bigger scandal than the problems faced by doctors and pharmacists, even though it has received low media attention so far, unfortunately. My view is that all decisions on the appropriate uses of medicines that are well-established in medical practice should be left to doctors, and the payer should reimburse the cost without interfering with the therapeutic process, just as payers do the world over. Let me repeat: we are not talking about expensive products here.

The anticipated increase in the cost of medicines for patients will definitely provide an impulse for the development of complementary insurance to cover the cost of those technologies that have been taken out of the package. It should be noted that in many cases they are innovative and the most efficacious medicines in a given indication. Many people will no doubt be willing to take out such policies, and my expectation is that first insurance products of this type will be launched on the market towards the end of 2012 or in early 2013, and definitely in 2014, when the directive on cross-border healthcare takes effect. For unless there are complementary insurance policies available, or a very high level of co-payment is established, or unless the mandatory healthcare contribution is significantly increased,

the NFZ budget will be unable to support the new system. The most likely scenario, in my view, is the development of complementary insurance, because the other two solutions are politically vulnerable and/or unrealistic in times of the economic crisis. According to my estimates, a policy paying for 27 innovative technologies will cost about PLN 15-25 (€3.6-5.9) a month depending on age, whereas a policy paying for 100-200 innovative technologies will cost PLN 100-150 (€23.8-35.6). These are very promising calculations.

What is your opinion about the functioning of the Agency for Health Technology Assessment in Poland (AOTM)? What areas of improvement do you see there?

The Agency operates under the light-touch model, which means that applicants, so companies file reimbursement applications together with supporting documents, and the AOTM's role is to evaluate their quality. In this respect it is doing a good job, in my view. The Reimbursement Act has introduced an additional requirement for the Agency to publish the full texts of the submitted analyses, which will further strengthen the transparency and public oversight of the AOTM's recommendations. The Agency could improve two things: one is to increase the number of assessments of non-drug technologies, i.e. medical devices and diagnostic technologies, though this will be rather difficult to achieve with the current staffing levels (just 6-7 people work on assessments of non-drug technologies). Here the AOTM should adopt the strong regulation model, actively searching for scientific evidence and preparing HTA reports. The other thing is assessments of the technologies that top the ranking list of Watch Health Care Foundation, i.e. benefits which are only theoretically guaranteed, but in practice unavailable. These technologies have excellent cost-effectiveness profiles (i.e. the ratio of cost to therapeutic outcome), because they are inexpensive and very efficacious.

What do you think are the chances for the introduction of an egalitarian approach to pricing and reimbursement of orphan drugs?

Indeed one of the major problems of the Reimbursement Act is the lack of an egalitarian procedure for the assessment of so-called orphan drugs and other technologies for rare and ultra-rare diseases. Despite repeated efforts to bring the issue to the attention of the Ministry of Health, the Act introduces only the criterion of cost-effectiveness. I expect that within four to six months this will lead to (entirely justified) protests by patients who are denied access to such medicines. The approval ratings of the ruling politicians are set to be affected. On this issue, my view of the new Act is very negative.

What are the advantages and disadvantages of the Polish health insurance system as compared with other countries in Central and Eastern Europe?

Countries such as the Czech Republic or Hungary have higher GDP per capita than Poland, which means that with a comparable guaranteed benefits package they get shorter waiting lists and better access to health services. The implication for us in Poland is that we should be more careful in managing our benefits package and that we should introduce complementary insurance, because holders of such policies would take some burden off the public system (they would not use it in case of illness). Complementary policies would also increase the pool of financial resources available in the underfunded system. Patients already contribute about PLN 30bn (€7.1bn) to the cost of healthcare benefits, but these resources are spent in the worst possible way, i.e. on a fee-for-service or out-of-pocket basis. Under the insurance model it would be possible to pay for many more benefits with a better structure and higher quality.