

Benefit package and costs of services – Health *Bascet*

Report I - POLAND

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Kraków – Warszawa March 2005

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Overview on benefit basket in the country

Health protection in Poland is a multisectoral issue, however it's the most important part belongs to the social protection system. Its legal basis was founded in 1997 in the Constitution where there is reference to entitlement to health services financed from public funds. Article 68 of the Constitution states that:

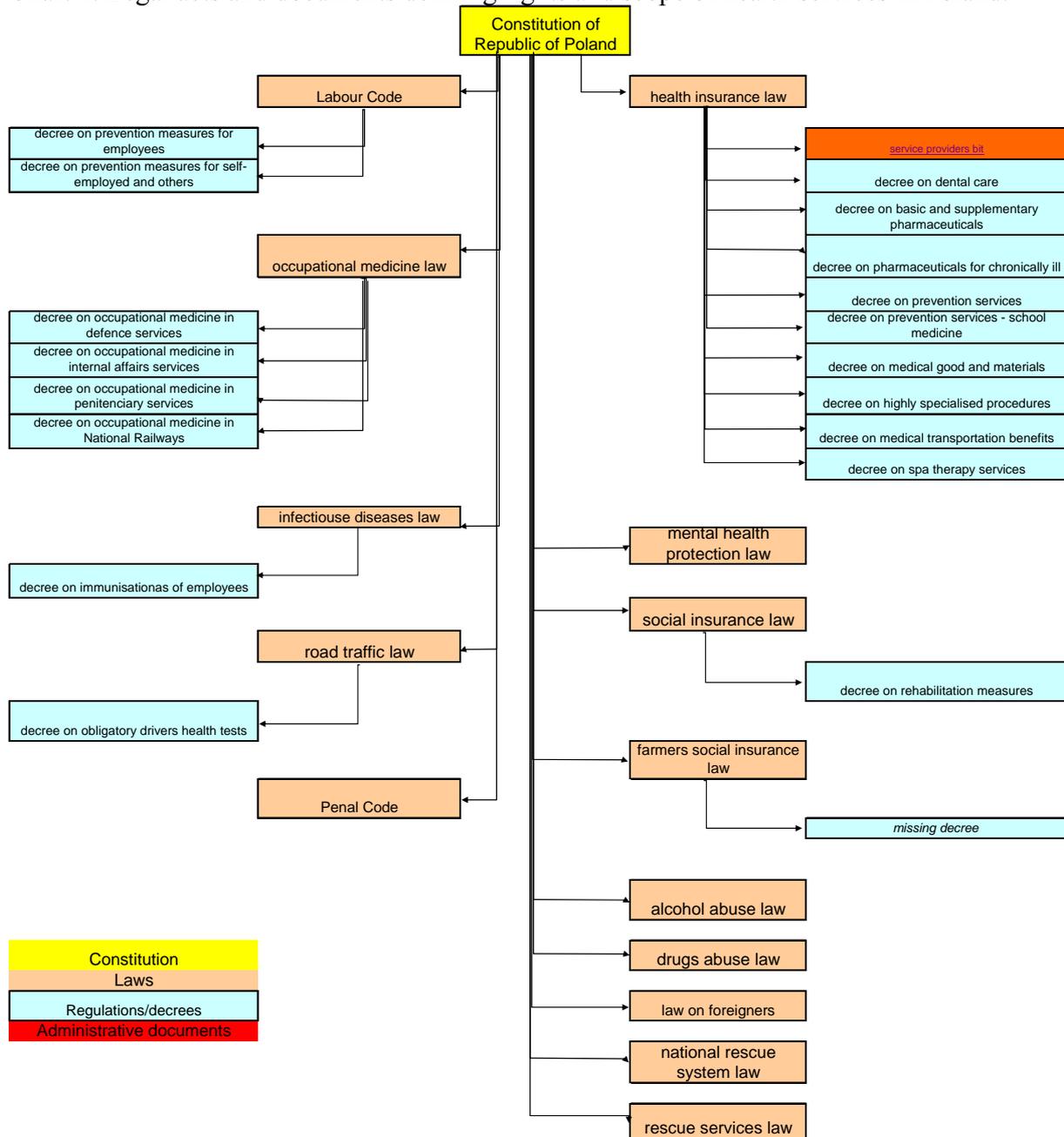
1. *Everybody has a right to health protection.*
2. *Citizens, regardless their economic status, shall be provided by public authorities with equal access to health care services financed from the public funds. Conditions and scope of services will be detailed in the appropriate law.*
3. *Public authorities are obliged to provide special health care services to children, pregnant women, disabled persons and elderly.*
4. *Public authorities are obliged to counter epidemic diseases and prevent potentially health-threatening outcomes of environment degradation*

The analysis of aforementioned rules allows to draw the following conclusions:

- Every person residing in an area covered by the legal protection of the Polish Constitution has a right to health protection. Such a rule provides that regardless of the nationality, citizenship and legal or economic status, i.e., each person residing in the territory of the country ***should experience the actions leading to health protection***.
- The citizens of the Republic of Poland have also some additional privilege consisting of *“equal access to health care services financed from public funds”*. Another rule says, *“the conditions and scope of services will be detailed in the appropriate law”*.

There is a number of various legal acts and documents defining the scope of services and conditions required for entitlement. A chart presenting them is placed below:

Chart 1. Legal acts and documents defining rights and scope of health services in Poland.



In the hierarchy of regulations the most important are those, which are derived from the Constitution. At the same time, however, they are the most general.

More specific are the laws adopted by Parliament and signed by the President of the Republic of Poland, which regulate certain areas of social life and activities, like:

- health insurance law – which is a regulation establishing a universal and obligatory insurance scheme, covering practically 99% of Polish citizens and a large part of non-citizens residents, both short and long term ones,
- labor code and occupational medicine law – which regulate relations between employers and employees, including health protection measures employers are obliged to implement,
- laws targeted to specific problematic health areas, e.g., infectious diseases, mental health, drugs and alcohol abuse problems – which regulate obligation

of public authorities and individuals regarding the protection against and coping with those specific problems.

- rescue system and services – regulating the functioning and financing of the national rescue system,
- social protection law – setting rules for social protection coverage for different population groups, both professionally active and non-active,
- penalty code – regulating the issues of crime and treatment of people committing crimes,
- law on foreigners – which regulates the rights and obligations of non-Polish residents who are under care of Polish authorities,
- road traffic code – regulating the rights and obligations of public roads users.

Many of those laws contain the so called delegations to regulations/decrees regulating on a technical level both the scope and conditions of services available to individuals in Poland. The underlying logic of the legislative process in Poland provides that laws establish the fundamental principles and mechanisms while regulations/decrees govern their practical application. Therefore, regulations/decrees cannot exceed the legal delegation set in specific law and they are issued by Ministers of Government.

The three levels described above are legal acts in understanding the Polish legislative system. They are obligatory by nature and there are legal and administrative sanctions for non-compliance.

Besides legal acts, there are some additional documents referring to benefit package which are not of legal nature. The most important among them and the only one discussed herein is a catalog of services (so-called “products”) which are purchased by the National Health Fund (NHF), the sole insurance institution that executes universal mandatory health insurance in Poland. The catalogs are appendices to procurement documentation in procedures of purchasing health services and goods within the universal health insurance system. The “products” included in catalogs are then the subject of contracts between the NHF and the services providers, to be provided to “beneficiaries”.

Public and private sources of financing and the benefit package

Public health expenditures amount to 70% of the total health expenditures in Poland. Private expenditures (estimated as 30% of total health expenditures) are almost completely out-of-pocket payments. The role of private health insurance (and quasi insurance) is very insignificant, and its total turnover does not exceed PLN 500 million (EUR 125 million). As far as private expenditures are concerned, no *benefit package* can be discussed; the only exception is occupational medicine, which will be further discussed below.

The majority of public expenditures on health are transferred through a health insurance fund, which is a part of the Polish social insurance system. The health insurance fund is managed by the institution of the National Health Fund (NHF) whereas the collection of premiums is done together with other social insurance premiums. The scope of services provided within the universal health insurance is the most important component of the so-called “benefit package”.

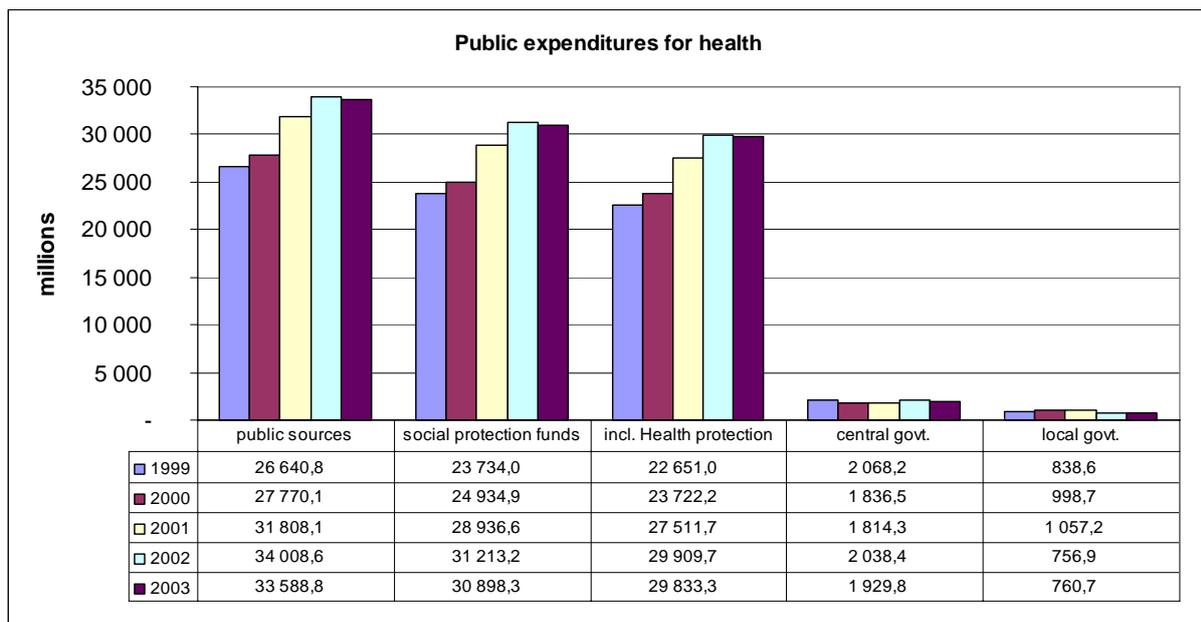
Social insurance is organized and managed by two institutions, separately regulated:

- Social Insurance Institution (ZUS) constructed for employees and self-employed persons and all other groups receiving income,
- Agricultural Social Insurance Fund (KRUS) – for all persons working in the agriculture

Both institutions are assigned to collect premiums for social insurance, for retirement, disability insurance as well as for social health insurance. Besides transferring the premium to the National Health Fund, they also purchase health services on their own – mainly rehabilitative care within the frame of disability prevention programs.

Another source of public funds in health care system is the state budget. Its main role is to transfer money to social insurance funds for non-contributing beneficiaries and to finance certain health functions mainly connected with public health.

The last category of public fund sources is local governments. Their role in provision of services is marginal and little regulated, apart from one exception related to prevention of substance abuse.



The major part of health services and goods are provided within the social health insurance system. Some characteristics of the system were already discussed above. Apart from universal health insurance, there are also other regulations granting certain groups of population the rights (sometimes the obligations as well) to specific health services and goods. The most important groups include:

- professionally active people, who benefit from occupational medicine,
- applicants for ill-health benefits who benefit from social security assistance in rehabilitation,
- prisoners who experience penitentiary health care.

- substance addicts (both alcohol and drugs) and their families who need health care related to the addiction,
- mentally sick, having free psychiatric health care and other kinds of care, if necessary,
- foreigners located in closed settings (incl. prisons), having access to health care of all kinds,
- all inhabitants of Poland, both temporary and permanent, using health services and goods related to prevention and treatment of certain infectious diseases,
- all persons staying permanently or temporarily in Poland, who have access to rescue (pre-hospital) services.

Roles of partners in defining the benefit package

As stipulated by law, the Polish Parliament is the supreme legislative body. The central government, respecting (in theory) a subsidiary principle, regulates the activities of both individuals and institutions, and, through central governmental administration and agencies, supervises their compliance to legal regulations. Local (regional) governments are responsible for public activities on their territories.

The rationale of the legislative process in Poland stipulates that laws use to establish principles and mechanisms, while regulations/decrees should establish practical application of the above. Regulations/decrees cannot exceed the legal delegation set in specific law and they are issued by each of Minister of Government.

The National Assembly, i.e., a joint session of the Lower and the Higher Chamber of Parliament (Sejm and Senate), adopts the Constitution with its provisions dedicated to health protection.

The Sejm drafts laws, which have to be approved by the Senate and signed by the President. In the area of interest, it defines:

- the general scope of health care available under universal health insurance,
- the “negative list” of services that are explicitly excluded from health insurance, on the law level,
- obligations to issue regulations/decrees by the Minister of Health or other governmental bodies, regarding health services and goods available under different laws,
- Other laws on provision of services and goods that are not related to health insurance

The Government, namely the Ministers, define various parts of the “benefit package” issuing regulations to existing legal provisions. The regulations identified which pertain to the issue of the “benefit package” are exhibited in Chart 1 and discussed in details later in the text. [The link directs the reader to active chart in an appropriate Excel file.](#)

The National Health Fund (NHF) defines a catalog of services (so-called “products”) which are purchased by the health insurance institution that implements universal mandatory health insurance in Poland. The catalogs are published as appendices to procurement documentation in the process of purchasing health services and goods within the universal health insurance system. The “products” from catalogs are later placed in contracts between the NHF and providers of services. In light of art. 68 of the Constitution, there may be some doubts if this procedure is legal, since the language stipulates that “*Conditions and scope of services will be detailed in the appropriate law*”. To some extent that problem was raised by Constitutional Tribunal in its verdict from February 2004, declaring that the (former) health insurance law was unconstitutional because (among others) it failed to define with sufficient precision the *scope of services* that beneficiaries may expect from the national health insurance scheme. The problem arising from the definition of the scope of services remains a public concern, and present and potential future solutions will be addressed later in the text.

Systemic exclusion

There are no services that can be considered completely excluded from all the subsystems discussed. Until recently, till accession to the European Union, practically excluded were services and goods which were not performed in the territory of Poland (although some exceptions took place). Since the accession, if there is a need for certain service, the service belongs to the national benefit package (e.g. implicitly), and the service is not available in Poland, a citizen may apply for treatment in another EU country, according to procedure E112 of Regulation 1408/71 and the Polish health insurance law.

There is a rule that cash benefits, connected with illness, are excluded from the social health insurance system. Cash benefits supplementing income loss are paid through the social insurance system while social health insurance system provides the benefits-in-kind type.

Services, which are excluded from the social health insurance system, will be discussed in detail below.

Short characteristics of the health care system

Having in mind the multisectoral character of health care provision, the most significant portion of health care in Poland is provided through the social health insurance system.

The Polish health care system prior to 1989 fell under the public integrated model, and was changing gradually all the time. This model represented a system in which government was both the principle insurer and the major provider of services. Third party payments were organized by public funding bodies, usually central, but later (after 1990) also local governments in which financing through compulsory income-related contributions via general taxation occurred. Employees were taxed (referred to as ZUS¹) roughly 50% of their income, for pension, healthcare and unemployment benefits. Due to lack of appropriate information systems, for a long time it was impossible to identify what portion of this tax was dedicated solely to healthcare. According to research conducted by the faculty of the School of Public Health in Kraków and the 1998 Statistical Bulletin published by the Ministry of Health in the 90s, roughly 15% of the state budget and 4% of GDP were allocated to healthcare. However, it is important to stress that in the past years the public in Poland had become accustomed to paying for health services and goods out of pocket. The reason is to obtain better quality and quicker access, the result being the creation of a purely private sector of health care (moonlighting doctors from the public sector), but also the "grey zone" of under-the-table payments within the public sector. Huge expenditures are spent on medicines, too. Data on out-of-pocket payment is estimated to 30% of total health expenditures.

Surpluses and shortages occurred due both to variations in local patterns as well as to political patronage. The compulsory catchment areas², which used to enforce patients to use a public provider operating in certain areas and the role of primary care doctors as "gate keepers" were unpopular with patients. Thus, the latter were willing to pay additional gratuities to be referred quickly up the line or/and use services outside their official catchment areas. Declaring to provide comprehensive and functionally integrated services, the system created many indirect barriers to access through adverse incentives and corruption.

The country had started to address the problems within its health arena as early as the 80's. The process was rather slow, however, and was basically focused on redefining the role of the state, which included a call for more efficient allocation of resources through *quasi-market* mechanisms, greater individual freedom through democratic processes and stronger institutional capacity of health systems through decentralized devolution of responsibility and management. In the 1994 small steps were taken which allowed the health facilities to fall under the gmina (local) and not the governmental administration of the regional level, thus giving health facilities a little more autonomy, under local supervision and protection at the same time. By the end of 1998 health care units (*ZOZ-es*)³ were also supposed also, to convert from budgetary units, depending entirely on the budget of "mother-administration", into so-called "*autonomous health care units*" which, remaining a public entity, started to operate like

¹ ZUS comes from Zakład Ubezpieczeń Społecznych, Social Insurance Fund and is responsible for collecting para-tax premiums, which are linked to incomes.

² Starting from 70s, the country was divided into ab. 400 catchment areas and the respective population was attached to a particular provider called ZOZ (Zakład Opieki Zdrowotnej). Within the structures of ZOZ there were primary care, specialist ambulatory care and hospital care units, composing a kind of "integrated care".

³ By that time ZOZ was already something different than before. This is a legal name of a health care unit, which is subject of registration (with elements of licensing) by the Voivod authorities.

semi-companies. The revenues of autonomous health care units until the end of 1998 were intended to come from their “*mother-administration*”, which was subsidized by the government and after 1st of January 1999, were expected from the Sickness Funds. Meanwhile many former public health care units were privatized becoming a property of the medical personnel which used to work there. However, the privatization process was not complete in most cases, i.e., buildings usually remained public property while equipment was sold out to the newly established medical companies.

On January 1st, 1999, the institutions of universal health insurance commenced their activity by virtue of the Law of Universal Health Insurance of 1997 with amendments from 1998. As a result, sixteen Regional Health Insurance (Sickness Funds) were established along with the Health Insurance Fund for the so called “uniformed workers”(army workers, policemen, railway workers) and their families, which operated on interregional level. According to the Law of Universal Health Insurance, Sickness Funds had to sign contracts with health care institutions. Regional Sickness Funds covered particular voivodships (administrative regions) populated by 1 to 6 million people. Since the year 2000, there were no legal barriers for the Sickness Funds to extend their activities to other regions. Citizens were free to choose the Sickness Fund irrespective of their place of living. Sickness Funds had become autonomous organizational and property institutions whereas still remaining public and managing funds collected through premiums under supervision of a public “board” with the principle aim of providing insofar as their budget allows, the best health care to all insured in their region. In reality, Sickness Funds did not compete much for patients from neighboring regions and were focused rather on preserving quality and “proper relations” with providers in their own regions. There were, however, some exemptions and certain Sickness Funds started to grab populations living in adjacent areas, creating examples of insurance competition within the public system.

The total of 7.5% (since 2004 it was 8.25%) of Poles’ income was allocated to the national health insurance. That contribution was defined by the parliamentary law. Due to the fact that this contribution was obligatory, the system was thus named universal, which means that all citizens paying and those who were not paying contributions were covered. Amounts were counted and deducted straight from citizens’ income. This was done by employers in case of employees while payments for the unemployed were made by the Ministry of Labor and other relevant agencies, pensioners had it deducted by the Social Insurance Institution. Farmers had their deductions made by the Farmers Social Insurance Scheme (KRUS), which was financially supported by the state budget. The collection and reporting of contributions was done both by KRUS and ZUS. Sometimes the system was called an “insurance-budgetary mix” because, besides the collection of about 22 billion zloty (in 1999 EUR 6 billion) coming to the Sickness Funds from premiums, there was about EUR 1.5 billion allocated from the state budget, which supported investments, some sorts of services (highly qualified) and the public health functions of the system.

In the year 2001, the new government declared centralization of the decentralized system by merging all sickness funds into a unified universal National Health Fund (NHF). The process of recentralization of the system lasted 2 years and was burdened with a lot of technical problems and shortcomings. It would be enough to say that in the period from 2001 until 2005 there were 6 Ministers of Health appointed and dismissed, and the Health Insurance Act was completely replaced 2 times, one being after the intervention of the Constitutional Tribunal which announced it as non-compliant with the Constitution of the Republic of Poland.

The National Health Fund is organized centrally although lately regional branches are again being given growing significance. There are 16 local offices that coincide with the

administrative division of the country and their management is responsible for contracting services in the region. Premiums are collected in the same way as before, through ZUS and KRUS (social insurance) structures, but the importance of central government spending is decreasing; by comparison the 1999 state budget expenditures reached EUR 1.5 billion euro while it dropped to only 1 billion in 2003, whereas social insurance premium collection rose from 6 to 8 billion for the same period of time.

Documents defining benefit package

Chart 1 presents documents and their mutual relation, which define the scope of benefits, entitlement to use them and sometimes the specific circumstances, when they are available for individuals. The list of legal documents is placed in the tables below.

In the table 1 there is a list of legal acts; laws and decrees, which determine benefit package in each of the existing subsystems. The level of detail in defining the scope of benefits to which persons are entitled to, differs in the acts. It is worth to notice that in each case of the acts says *who* is entitled (covered) by certain kind of protection and *what* protection is it, sometimes defining also under what circumstances and conditions it is available.

The legal acts presented on yellow background in the table 1, are laws, and those on white are decrees. As decrees are always based on legal delegation from a law, the table presents relation between the two types of acts.

Besides laws and decrees there are also Constitution of the Republic of Poland and services providers bid documentation, which is not a legal act.

For purpose of this paper, there were three levels of explicitness distinguished, as regards the definition of the benefit package:

Explicit – what is understood as enlisting specific medical procedures, (eg. immunization for hepatitis B); an equivalent of the grade 3 in scale of explicitness which was presented in table 3.

Semi-explicit – what is understood as pointing out certain area of health care, to which beneficiaries have rights (eg. primary care)); an equivalent of the grade 2 in scale of explicitness which was presented in table 3.

Implicit – what is understood as mentioning generally, that health care is provided, sometimes with additional formulation as *all necessary, efficient* etc.); an equivalent of the grade 1 in scale of explicitness which was presented in table 3.

Each of the acts was assessed according to this scale, the results were presented in the table 1. In some of the acts some benefits are determined in more detail and some other in less detail, what means that level of explicitness of benefit package defining ranges from *implicit* to *explicit*, however usually it regards different areas of health care. As a rule, decrees are more detail in benefits definition than laws, and the laws are more specific than Constitution. However in case of the most prominent act; Universal Insurance Law, the act encloses benefits definition on all three levels.

Table 1. List of documents determining benefit package and its level of explicitness.

Document/act	Explicit	Semi-explicit	Implicit
Constitution			v
health insurance law	v	v	v
. decrees on dental care	v		
. decrees on basic and supplementary pharmaceuticals	v		
. decrees on pharmaceuticals for chronically ill	v		
. decrees on prevention services	v		
. decrees on prevention services- school medicine	v		
. decrees on medical good and materials	v		
. decrees on medical good and materials	v		
. decrees on medical transportation benefits	v		
. decrees on spa therapy services		v	
. decrees on highly specialised procedures	v		
. <i>service providers bid documentation</i>	v		
mental health protection law			v
social insurance law			v
. decrees on rehabilitation measures		v	
farmers social insurance law			v
. <i>missing decree</i>			
Penal Code		v	
alcohol abuse law		v	
drugs abuse law		v	
law on foreigners			v
national rescue system law			v
rescue services law			v
Labour Code			v
. decrees on prevention measures for employees		v	
. decrees on prevention measures for self-employed and others		v	
occupational medicine law		v	
. decrees on occupational medicine in defence services	v		
. decrees on occupational medicine in internal affairs service	v		
. decrees on occupational medicine in penitentiary services	v		
. decrees on occupational medicine in National Railways	v		
infectious diseases law		v	
. decrees on immunisations of employees	v		
. decrees on obligatory immunisations	v		
road traffic law		v	
. decrees on obligatory drivers health tests	v		

Full names and legal addresses of the acts are placed in table 2.

Table 2. Full names and legal addresses of legal regulations defining benefit package in Republic of Poland.

Full name	Document/act	
Constitution of Republic of Poland of 1997	Constitution	
Law of 27/08/2004 on health services provided from public sources	health insurance law	
Regulation of the Minister of Health of 24/11/2004 on the list of guaranteed benefits of dentist and dental substances and of documents confirming the authorization of these evidences	.	decree on dental care
Regulation of the Minister of Health of 17/12/2004 on the list of the basic and complementary medicines and the level of repayment for the complementary medicines	.	decree on basic and supplementary pharmaceuticals
Regulation of the Minister of Health on the list of diseases and list of medicines and medical products, which, in view of these diseases, are prescribed as free of charge, flat-rate payment or partial payment.	.	decree on pharmaceuticals for chronically ill
Regulation of the Minister of Health of 21/12/2004 on the range of wholesome care services, including sifting tests and periods in which these tests are made	.	decree on prevention services
Regulation of the Minister of Health of 22/12/2004 on the range and organization of prophylactic wholesome care over children and youth	.	decree on prevention services- school medicine
Regulation of the Minister of Health of 17/12/2004 on detailed list of medical products which are being orthopaedic ones and aids, level of recipients own participation in the costs of these products, criteria of adjudicating, periods of use, and also medical products which are being orthopaedic ones subjected to repair in dependence from medical indications and these articles and aids supply order formula	.	decree on medical good and materials
	.	decree on medical good and materials
Regulation of the Minister of Health of 17/12/2004 on list of disease units' groups, levels of handicap and level of recipients own participation in the fares of sanitary transportation	.	decree on medical transportation benefits
Regulation of the Minister of Health of 15/12/2004 on health resort treatment	.	decree on spa therapy services
Regulation of the Minister of Health of 13/12/2004 on high-specialized evidences financed from state budget, from the part being under disposition of the minister adequate to health cases	.	decree on highly specialised procedures
	.	service providers bit documentation
Law of 19/08/1994 on psychiatric health care (L.o.l., nr 111, pos. 535, with lower changes)	mental health protection law	
Social Insurances System Law of 13/10/1998 (Letter of Issues nr 137, pos. 887 with lower changes)	social insurance law	
Council of Minister Decree of 12/10/1998 on detailed rules and modes of directing by Social Insurance Institution on healing rehabilitation and granting orders onto rehabilitation services. (L.o.l nr 131, pos. 1457	.	decree on rehabilitation measures
Law of 20/12/1990 on social insurance of farmers and their families (Letter of Issues of 1998 nr 7, pos. 25 with lower changes)	farmers social insurance law	missing decree

Law of 6/06/1997 – Executive Penal Code (L.o.I. nr 90, pos. 557 with lower changes)	Penal Code
Law of 26/10/1982 on nurture in sobriety and alcoholism counteracting (L.o.I. from 2002, nr 147, pos. 1231, with lower changes)	alcohol abuse law
Law of 24/04/1997, on counteracting the drug addiction (L.o.I. from 2003, nr 24, pos. 198 and nr 12, pos. 122, pos. 1143)	drugs abuse law
Law of 13/06/2003 on foreigners (L.o.I., nr 128, pos. 1175 and from 2004, nr 96, pos. 959 and nr 179, pos. 1842)	law on foreigners
Law of 19/08/1994 on National Medical Rescue (L.o.I., nr 113, pos. 1207, with lower changes)	national rescue system law
Law of 19/08/1994 on provision the services of medical rescue (L.o.I., nr 241, pos. 2073 and from 2003, nr 99, pos 920)	rescue services law
Code of Work (Law of 26/06/1974. Code of Work – uniform text, Letter of Issue nr 21 from 1998, pos. 94 with lower changes)	Labour Code
Regulation of Minister of Health and Social Care of 30/05/1996 on medical delving of employees, the range of preventive wholesome prophylactic care of employees and medical statements given for purposes provided in Code of Work (L.o.I. nr 65 of 25/06/1996, pos 332)	decree on prevention measures for employees
Regulation of Minister of Health and Social Care of 15/09/1997 on performing by medicine of labour service prophylactic wholesome care in relation to people covered with this care upon their own proposal	decree on prevention measures for self-employed and others
Law on medicine of work service of 27/06/1997 (L.o.I nr 96, pos. 593). This act took effect 1/01/1998	occupational medicine law
Regulation of Minister of National Defence of 15/06/1999 on medicine of work service in organization units subordinated or supervised by Minister of National Defence (L.o.I nr 61 from 1999, pos 665 with lower changes)	decree on occupational medicine in defence services
Regulation of Minister of Interior and Administration of 25/09/2001 on assignments of medicine of work (L.o.I nr 118 from 2001, pos 1270)	decree on occupational medicine in internal affairs services
Regulation of Minister of Justice of 29/05/2003 on assignments of medicine of work service as result of peculiarity of professional risk in organization units of Prison Service	decree on occupational medicine in penitentiary services
Regulation of Minister of Transportation and Sea Economy of 28/06/1999 on assignments of medicine of work service as result of peculiarity of professional risk people engaged in railway transportation (L.o.I nr 61 from 1999r, pos. 674)	decree on occupational medicine in National Railways

Law of 6/09/2001 on infectious diseases and contagions (L.o.l nr 127 from 2001, pos 1384 with lower changes)	infectious diseases law	
Regulation of Minister of Health of 03/01/2003 on work positions and immunizations indicated to realization by employees taking job or employed on these positions	.	decree on immunisations of employees
	.	decree on obligatory immunisations
Acts of 20/06/1997 on road traffic (L.o.l nr 58 from 2003, pos .515 with lower changes). Chapter IV, art. 123 and art. 124	road traffic law	
	.	decree on obligatory drivers health tests

Implicit and explicit definitions of benefit package

Table 3 presents identified areas/subsystems of health care where regulations regarding *benefit package* appears along with their characteristics. In consequence the individual legal acts which were presented in tables 1 and 2, were aggregated into following areas:

- social health insurance system – regulated by health insurance law and related decrees. To this system services providers bid documentation belongs, which is not a legal act, but was discussed here because of its role in the system,
- social insurance system – which is a wider concept than social health insurance, but here it contains functions regulated by social insurance law and farmers social insurance law, and related decrees

The areas indicated start from the social health insurance system, which is the most important “payer” of services in Poland. The tables depict what kind of document regulates the *benefit package* in each subsystem (law, regulation or non-legal document) and what is the level of precision in determination of the benefit package, which refers to the distinctions mentioned above (1 the least precise, 3 the most precise).

Table 3. Benefit package and an explicitness of its description in distinguished areas.

Legal status/functional categories:	Social health insurance system			Social insurance system			Occupational medicine			Rescue system			Mental health and substance abuse			Infectious diseases			Prisoners, foreigners under state care		
	L	R	A	L	R	A	L	R	A	L	R	A	L	R	A	L	R	A			
HC.1 Services of curative care																					1
HC.1.1 In-patient curative care															1						
acute inpatient care - somatic	2		3							2		3	1			1					3
acute inpatient care - intensive care	2		3																		
special area: transplantation	2	3	3																		
(acute) inpatient care - mental	2		3										1								
HC.1.2 Day cases of curative care														1							
specialist outpatient care - day surgery	1		3																		
special area: hemodialysis			3																		
HC.1.3 Out-patient care														1		1					3
HC.1.3.1 Basic medical and diagnostic services														1		1					
(curative) primary care	2		3																		
HC.1.3.2 Out-patient dental care														1		1					3
dental prophylaxis, care, surgery	2	3	3																		
HC.1.3.3 All other specialised health care														1							
specialist outpatient care - somatic	2		3																		
specialist outpatient care - mental; special area: psychoanalysis, -therapy	1		3											1							
HC.1.3.9 All other out-patient curative care														1							
ambulatory services by other professionals: physiotherapy, ergotherapy, logopedy, chiropedy, podiatry, dietetics, optometry ...	2		3																		
alternative & complementary medicine – services (TCM, acupuncture, balneotherapy ...)	2		3																		
HC.1.4 Services of curative home care	2		3																		
HC.2 Services of rehabilitative care																					1
HC.2.1 In-patient rehabilitative care														1		2					
inpatient rehabilitation	1		2	1	2	3															
HC.2.2 Day cases of rehabilitative care	1		3											1		2					
HC.2.3 Out-patient rehabilitative care														1		2					
ambulatory rehabilitation	1		3	1		3															
HC.2.4 Services of rehabilitative home care	1		3											1		2					
HC.3 Services of long-term nursing care																					
HC.3.1 In-patient long-term nursing care														1							
inpatient long-term care services	2		3																		
special area: hospice care	2		3																		
HC.3.2 Day cases of long-term nursing care	1		3											1							
HC.3.3 Long-term nursing care: home care														1							
ambulatory long-term care services	2		3																		
HC.4 Ancillary services to health care																					1
HC.4.1 Clinical laboratory														1		2					3
laboratory tests	2		3																		
HC.4.2 Diagnostic imaging														1		2					3
diagnostic imaging, i.e. ultrasound, X-ray, CT, NMR	2		3																		
HC.4.3 Patient transport and emergency rescue														1							
patient transportation	2	2	2							1		2									
HC.4.9 All other miscellaneous services																					
HC.5 Medical goods dispensed to out-patients																					1
HC.5.1 Pharmaceuticals and other medical non-durables														1							
HC.5.1.1 Prescribed medicines	2	3												1		2	3				2
HC.5.2 Therapeutic appliances and other medical durables																					
HC.5.2.1 Glasses and vision products	2	3																			
HC.5.2.2 Orthopaedic appliances and other prosthetics	2	3																			
HC.5.2.3 Hearing aids	2	3																			
HC.5.2.4 Medico-technical devices, incl. wheelchairs	2	3																			
HC.5.2.9 All other miscellaneous medical durables																					
goods: medical devices for patient use (from dressings via glasses to wheel chairs)	2	3																			
HC.6 Prevention and public health services																					1
HC.6.1 Maternal and child health; family planning and counselling														1		2					3
reproductive health (maternal care, birth, abortion, IVF, contraception, sex change ...)	2	2	3																		
HC.6.2 School health services	2	2	3																		
HC.6.3 Prevention of communicable diseases	1	2	3																		
HC.6.4 Prevention of non-communicable diseases														1							
health promotion, primary prevention, immunizations, screening	1	2	3																		
HC.6.5 Occupational health care										1	2										
HC.6.9 All other miscellaneous public health services														1							

Catalogue: type of document, actors and	Social health insurance system				Social insurance system				Occupational medicine				Rescue system				Mental health and substance abuse				Infectious diseases				Prisoners, foreigners under state care			
	Legal status: law, decree ...	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract	Law	regulation/d ecree	Administrative document/C ontract
Decision-maker	Parliament	MoH	NHF	Parliament	Minister of Social Affairs	Social Fund	Parliament	Ministers		Parliament		NHF	Parliament	Ministers	local administrati on	Parliament	Ministers	NHF	Parliament									
(original) purpose, e.g. entitlements, reimbursement, target-setting	entitlements	reimburse ment	purchasing	entitlements	entitlements	purchasing	entitlements	entitlements		entitlements		purchasing	entitlements		purchasing	entitlements	entitlements/ reimburse ment	purchasing	entitlements									
Positive/ negative definition of benefits	P,N	P	P	P	P	P	P	P		P		P	P		P	P	P	P	P									
Degree of explicitness: 1 "all necessary"/	1,2,3	2,3	3	2	2	3	1	2		1,2		2,3	1		2	2	3	3	1									
If itemised: goods/ procedures only; linked to indications	procedures/ linked to indications	goods/proce dures/ linked to indications	procedures/ linked to indications							procedures				linked to indications			procedures/ linked to indications	goods/proce dures/ linked to indications	procedures/ linked to indications									
Updating	Occasionall y	Occasionall y/Regularly	Regularly	Occasionall y	Occasionall y	Regularly	Occasionall y	Occasionall y		Occasionall y		Occasionall y	Occasionall y		Regularly	Occasionall y	Occasionall y/Regularly	Regularly	Occasionall y									
Criteria used for defining benefits																												
* need	X	X	X	X	X	X	X	X		X		X	X	X	X	X	X	X	X									
* costs			X			X						X			X			X										
* effectiveness	X	X		X	X					X			X	X		X	X								X			
* cost-effectiveness																												
* budget			X			X						X			X			X						X				
* other: lobbying		X	X		X	X		X																				

Definitions of entitlements and benefits by sector - Social health insurance system

For two years after the introduction of the compulsory health insurance in 1998 there were political debates regarding the type of funds being at the disposal of sickness funds. Lastly, in the year 2000 the Polish Parliament (the Sejm) decided to change the public procurement act by introducing the rule providing that sickness funds have to apply the legal procedures for public procurement as any other public body. This served as indirect evidence that sickness funds' spending was considered public money and hence article 62 of the Constitution should apply to them as well.

Eventually, the year 2000 brought the final clarification. Public funds had been described in the Public Funds Act and included money within the state budget, the National Health Fund, local governments and public health care providers, regardless of the source of funding⁴.

Despite the fact that the expression "Polish citizens" means all citizens, it is important to note the narrowing definition of "*equally entitled to public health services*" in the Compulsory Health Insurance Act. According to it, this category comprises only persons covered by health insurance. The broadest scope of utilisation of public health benefits was found among those covered by compulsory health insurance since 1999. Also, before the introduction of compulsory health insurance law, there were people in Poland who had Polish citizenship but were not covered by social insurance, especially regarding health care benefits in kind.

When the new law on health care services financed from public sources was being prepared in 2003, the legislative body had been aware of the legal status of public funds in the National Health Fund, but even so it limited the scope of the law. It can be presumed that the legislative body decided that words "conditions and scope" from the Constitution address not only the services, but also the conditions on which citizens obtain public health services. There is some inconsistency, however, if highly specialized procedures financed from the state budget are considered, the entitlement to those procedures in the period of 1999-2001 was broader and every citizen could receive such services not only those covered by health insurance⁵.

Finally, the Law of 27/08/2004 on health care services funded from public resources (Letter of Issue No 210 from year 2004 pos. 2135)⁶ was adopted to replace compulsory health insurance in National Health Fund act; it introduced two categories of persons entitled to publicly funded health care services:

- 1) persons covered by universal – compulsory and voluntary health insurance, called "insured persons"
- 2) other than insured persons, people with Polish citizenship and with place of residence on the territory of Poland, who meet income criteria established in the social support

⁴ Kawiorska D, Kozierekiewicz A., *Wydatki publiczne na ochronę zdrowia – definicje i porównania międzynarodowe*, Zdrowie i Zarządzanie, tom V, nr 2/2003, str. 9-25

⁵ Personal communication with J. Gralińskim, MD; ~~former one-time~~ Head of the Department of Public Health in Ministry of Health

⁶ Act from 27/08/2004 on health services financed from public funds

act⁷

Both groups are named with the same term, i.e., „beneficiaries”.

There is also a third group: persons not having Polish citizenship, other than beneficiaries, who are entitled to health care services on the basis of other specific rules and international agreements.

Regulation 1408/71/EC is an example of such specific rule. Under its provisions and appropriate delegations in the act, a certain group of people is entitled to public health care services even though they are not insured in the National Health Fund. The entitlement of those people is based on the legal framework of the other (than Poland) EU Member State, or the EFTA member states and it is regulated by the rules on the coordination of social protection in the EU.

The Constitution describes also the special type of citizens – children, pregnant women, disabled persons and the elderly - to be covered by the special type of health protection, which should be interpreted as health care surpassing the generally available services. This rule suggests also that all agreements regarding the scope and condition of health care provision should encompass special entitlements for those social groups. Otherwise, regulations remain not fully executed. Therefore, there are some articles in the health services act, pointing at the special rules concerning pregnant women and children.

The most important one is article 13, which provides entitlement to services despite lack of any legal entitlement, although limited to Polish citizens residing in the territory of Poland.

Article 13.

1. Beneficiaries other than insured persons, who:

- 1) are under 18;
- 2) are pregnant, in delivery or postpartum period

- have the right to health care services on the same conditions and scope as insured persons.

2. Pharmaceuticals, medical and auxiliary products are provided to persons described in the paragraph 1 point 2 if it is necessary to pregnancy, in delivery or postpartum period.

Besides aforementioned regulations providing entitlement to health care services within compulsory health insurance, there are some other rules encompassed in medical ethics and in an act regulating the profession of medical doctors and the management of health care institutions. They explicitly state there is an obligation to provide the health services required in an emergency health or life threatening situation to any person. However, the limits to such intervention are rather blurred and do not suggest whether services should be limited to saving lives or should go further if the life threatening condition remains.

⁷ Act from 12/03/2004. on social support (Dz.U. Nr 64, poz. 593 i Nr. 99, poz. 1001)

The scope of benefits - inclusions

The act on health care services financed from public funds has the following provision:

Article. 15.1. Beneficiaries have, under the provision set in the act, right to health care services that aim at protection of health, prevention of diseases and injuries, early detection of diseases, treatment, nursing and prevention of disability and its minimization.

2. Beneficiaries are provided with publicly funded services:

- 1) diagnostic tests including medical laboratory diagnostic;
 - 2) services aiming at protection of health, prevention of diseases and injuries, early detection of diseases, including compulsory vaccinations;
 - 3) primary health care;
 - 4) services in the educational environment;
 - 5) outpatient specialist services;
 - 6) medical rehabilitation ;
 - 7) dentistry services;
 - 8) hospital treatment;
 - 9) highly specialized services;
 - 10) home care;
 - 11) psychological examination and treatment;
 - 12) logopaedics examination and treatment;
 - 13) nursing care, including hospices and palliative care;
 - 14) nursing of disabled ;
 - 15) antenatal care;
 - 16) care over women during the breastfeeding period;
 - 17) prenatal care and newborn care as well as preliminary newborn's health and development assessment
 - 18) care over healthy child , including health and development assessment of child up to 18 years old;
 - 19) spa treatment;
 - 20) provision of therapeutic products, medical and auxiliary products;
 - 21) medical transport;
 - 22) emergency care.
3. Minister of Health, after consultation with the Polish Chamber of Physicians and Dentists and the Polish Chamber of Nurses and Midwives shall detail in the appropriate regulation:
- 1) the list and the scope of highly specialized health care services that are financed from the state budget;
 - 2) the manner of transferring public funds for the provision of those services;
 - 3) the manner of price setting and reimbursement of those services;
 - 4) bodies performing the quality assessment of those services
- especially considering the requirements for special qualifications of the health professionals and necessity of utilization of special medical devices.

The following articles of the act stipulate the circumstances and conditions under which particular types of services are to be provided. The main requirement is the referral from the physician working in the health insurance system, despite the fact that there are services for which a referral is not required.

The Minister of Health has also several legal obligations for issuing the regulations forming partially the "health basket". These are specifically:

- Regulation on screening tests and the periods when they are provided to risk groups;
- Regulation on the list of guaranteed services provided by dentists and dentistry materials and the document verifying entitlement.
- Regulation on the list of basic and complementary drugs and the level of payment for complementary drugs;
- Regulation on the list of diseases and drugs and medical products, that shall be provided free of charge or for the lump sum or partial payment;
- Regulation on the scope and management of preventive care for children and adolescents.
- Regulation on detailed list of medical or auxiliary products, level of co-payment, eligibility criteria and periods of utilization.
- Regulation on the list of diseases, levels of disability and level of co-payment for medical transport.
- Regulation on spa treatment.
- Regulation on the highly specialized procedures financed from the state budget.

The scope of benefits - exclusions

According to article 16 of the act on health care services financed from public funds, the benefit package does not cover the following services:

1. reimbursement of the cost of decrees required for driving license and other decrees on the request of the patient unless they are related to continuity of treatment, rehabilitation, incapacity for work, continuity of education, etc.
2. reimbursement of the cost of decrees and necessary medical procedures related to disability pension

Necessary judgments, decrees and costs of forensic expertise done on the request of the court or prosecutor are covered by separate public funds.

Moreover, all patients staying at nursing homes have to cover the costs of food and accommodation. Maximum monthly payment cannot be higher than 250% of the lowest pension, but in a certain case a fee cannot exceed 70% of a patient's pension. The same rule applies to children under 18 residing in nursing homes, however, in this case a monthly payment cannot be higher than 200% of the lowest pension and not exceeding 70% of income per capita in a particular family.

There is also a negative list of services excluded from the guaranteed public health services package. It includes:

1. Services excluded from the public benefits package regardless the scope of their provision:
 - 1) vaccinations that are not included in the compulsory vaccination package;
 - 2) plastic and cosmetic surgery when it is not necessary treatment for malformation, injury, illness;
 - 3) sex change operations;
 - 4) acupuncture, unless it is a part of chronic pain management ;
 - 5) spa and rehabilitation spas that are not directly connected to cause of the referral for spa treatment;
 - 6) sexual counseling in outpatient clinics, unless it is provided to people with high level of disability;
 - 7) poradnictwo psychoanalityczne;

- 8) ozone therapy ;
 - 9) auto vaccines;
 - 10) magnetic therapy with the use of magnetic field;
 - 11) laser puncture;
 - 12) acupressure;
 - 13) zoo therapy;
 - 14) diagnostic and therapy in unconventional medicine, traditional medicine or oriental medicine.
2. Services excluded from the public benefits package only in the certain scope of provision:
- 1) health care services within nervous system:
 - a) treatment of epilepsy with stimulation of n. vagus,
 - b) diagnostics and treatment of the taste disorders,
 - c) hyperbaric chamber in the SM treatment,
 - d) administration of baclophen with an infusion pump, unless it is the only possible therapeutic option;
 - 2) services of the endocrine system: endoscopic transorbital decompression in Graves ophtalmopathy, unless it is a sight saving procedure in optic nerve pressure.
 - 3) services performed on the eye:
 - a) refractive surgery in sight disorders correction,
 - b) laser stimulation of macula lutea,
 - c) alloplastic of temple arteries;
 - 4) services of the cardiovascular system – implantation of two cavities defibrillator with atrium and ventricle defibrillation;
 - 5) services of the blood and lymphatic system – banking of the newborn’s own umbilical cord blood;
 - 6) Services of the digestive system:
 - a) evaluation of digestive tract with endoscope capsule,
 - b) removal of hemorrhoids with Longo’s method,
 - c) hydrocolonotherapy;
 - 7) services performed on male genitals:
 - a) taking the sperm from epididymis,
 - b) obliteration of testicle vein using a fluoroscopic method,
 - c) penis prosthesis implantation;
 - 8) obesity, unless there is a pathological obesity with BMI >40 treated with surgical procedures;
 - 9) diagnostic services - PET, unless there is:
 - a) single metastasis of unknown source in order to locate the primary tumor when it is not possible to locate it using other diagnostic procedures,
 - b) single lung tumor in order to differentiate benign and malignant type when other diagnostic is not successful
 - c) lung cancer in order to perform pre-surgery evaluation of its advancement, if its not possible to evaluate the advancement with other diagnostic procedures
 - d) Hodgkin's disease in order to evaluate preliminary and final evaluation of the efficacy of chemotherapy, early detection of relapse if CT does not provide sufficient information,
 - e) ischemic health disease in order to evaluate frozen health muscle,
 - f) prior to heart transplantation in order to preclude irreversible damage,
 - g) epilepsy in order to locate its primary location,
 - h) soft tissue sarcomas in order to evaluate the efficacy of chemotherapy after two courses and early detection of relapse,
 - i) breast cancer for pre-surgery evaluation of its advancement,
 - j) ovarian cancer for early detection of relapse,
 - k) thyroid gland cancer in order to locate the focus of relapse when the thyreoglobuline has risen,
 - l) suspicion of bone metastasis, if other diagnostic does not allow to locate a focus of relapse,,

- m) planned radical radiotherapy
- n) radiosurgical treatment of early lung cancer in order to preclude other malignant focuses

Moreover, according to article 25 of the act, the National Health Fund does not reimburse costs of treatment or diagnostics of insured person incurred abroad unless those services were provided in accordance with the Regulation on coordination. Therefore, the NHF chairman issues the insured person on his/her request approval for treatment or diagnostic abroad.

National Fund catalog of “products”

On the basis of the regulations and previously presented legal provisions, the National Health Fund defines the so-called “products” that are purchased in the scheme. The catalog of health care products includes a number of parts/chapters, as envisaged in Table 6.

Table 6. Categories of “products” purchased by NHF with classification to SHA categories and short description. Valid for 2005.

	NFZ products	SHA category	Description
1	Primary care	HC.1.3.1 Basic medical and diagnostic services HC.6.1 Maternal and child health; family planning and counselling HC.6.2 School health services HC.6.3 Prevention of communicable diseases	Primary care is provided by general practitioners, but also by pediatricians, internal medicine specialists. The care is supported by GP nurses and midwives. The category contains also school nurse activity
2	Ambulatory care - surgical	HC.1.3.3 All other specialised health care	This category contains ab. 50 invasive procedures provided by ambulatory care physicians
3	Ambulatory care - medical and diagnostics	HC.1.3.3 All other specialised health care	This category contains consultation services of ambulatory care physicians, together with a set of diagnostic tests which have to be provided by them, on their own cost
4	Ambulatory care - diagnostics	HC.4.2 Diagnostic imaging	This category contains 22 imaging procedures financed separately
5	Hospital care - general	HC.1.1 In-patient curative care	This category contains ab. 1400 different hospital care cases; both surgical (with invasive procedure) and medical (conservative therapy)
6	Hospital care - radiology, nuclear medicine	HC.1.1 In-patient curative care HC.1.2 Day cases of curative care	This category contains nuclear medicine therapies, provided with or without hospitalization.
7	Hospital care - oncological therapy	HC.1.1 In-patient curative care HC.1.2 Day cases of curative care	This category contains chemotherapy of neoplasms, both in hospital care and day care

8	Hospital care - non-oncological therapy	HC.1.1 In-patient curative care HC.1.2 Day cases of curative care	This category contains chemotherapy for non-oncological cases (e.g. Hepatitis B), provided both in hospital and day care
9	Dentistry - children	HC.1.3.2 Out-patient dental care	This category contains ab. 40 procedures available for children (up to 18 years) only
10	Dentistry - general	HC.1.3.2 Out-patient dental care	This category contains ab. 70 procedures available for all insurees
11	Dentistry - pregnant women	HC.1.3.2 Out-patient dental care	This category contains services which are available for free for pregnant women only
12	Spas	HC.2.1 In-patient rehabilitative care HC.2.3 Out-patient rehabilitative care	This category contains rehabilitative and treatment services available in spas (a category of settings), both in inpatient and ambulatory manner
13	Emergency	HC.4.3 Patient transport and emergency rescue	This category contains rescue and emergency transportation services, both air and ground
14	Separately contracted services	HC.1.2 Day cases of curative care (incl. Hemodialysis)	This category contain ab. 20 not otherwise classified services, mainly provided in day care (incl. Hemodialysis, oxygen therapy etc.)
15	Psychiatric and substance abuse therapy	HC.1.1 In-patient curative care - mental HC.1.3.3 All other specialised health care - mental HC.1.2 Day cases of curative care - mental	This category contains services provided by psychiatrists, in all kinds of settings
16	Rehabilitation	HC.2.1 In-patient rehabilitative care HC.2.2 Day cases of rehabilitative care HC.2.3 Out-patient rehabilitative care HC.2.4 Services of rehabilitative home care	This category contains rehabilitation services provided by physicians and physiotherapists, in all kinds of settings
17	Long term care	HC.3.1 In-patient long-term nursing care HC.3.2 Day cases of long-term nursing care HC.3.3 Long-term nursing care: home care	This category contains long term nursing care, but also paliative care and hospices, in all kinds of settings
18	Health promotion & prevention	HC.6.4 Prevention of non-communicable diseases	This category contains prevention and early detection programs for non communicable diseases

The catalog is not published in a uniformed way; it is rather a set of appendices to different models of contracts with various groups of providers. It is published in an electronic form usually in October of the year preceding the year of contracting. Table 6 was developed for the project purposes and is not an official publication of the NHF but an aggregate of product list from a variety of NHF internal documents.

[A hyperlink to the Excel file of the catalog is placed here.](#)

Regulations regarding drug reimbursement

The provisions concerning medicines (drugs) and medical supplies in the Polish health care system were assessed by international experts[1] and found as “extensive”.. More than 6,700 pharmaceutical products, including all their forms and dosages, have been registered in Poland and about 2,700 have been placed on the basic and supplemental lists. Insured persons admitted to hospitals and other stationary health care centers are provided with drugs without charge⁸. Drugs for ambulatory patients on a physician’s prescription, which should be administered at home, are reimbursed according to a defined list determined by the Minister. Drugs on the list are divided into two categories:

- 1 basic medicines and magisterial preparations;
- 2 complementary medicines.

The third group of drugs registered in Poland which are not included in any of the lists are not subject to any reimbursement.

Basic medicines are reimbursed to a fixed cost determined by the Minister. Patients pay only PLN 2.5, regardless of the actual price of the drug while the rest is covered by their insurer. Complementary drugs are reimbursed at 70% or 50% of the drug price, depending on which list it has been placed on.

According to the law adopted by Parliament in 2001, prices of drugs are determined in a negotiation process between producers (or their trade agent) and the Minister of Health, when the Ministry decides reimbursement. The lists of reimbursable drugs should be updated at least once a year which did not happen in 1999 and 2002, thus, there has been only one change of the list.

The Ordinance on Drugs does define the lists of drugs belonging to the basic and complementary categories (including 50% and 70% reimbursement rates) and the amount to be reimburses as stipulated in the Act. Drugs “without any charge” are provided in following cases:

- As part of hospital care (with respect of the fact explained in footnote 1),
- As part of national programs, such as “highly qualified services” (described in the next chapter),
- For patients who are “voluntary blood donors”,
- For patients who are war and military invalids and their family members,
- For patients with one (or more) of enlisted diseases - “indications” (mostly chronic diseases) (although a separate list picks some of these out for only partial reimbursement). The list contains the following diseases: 1) Prostate cancer; 2) Breast cancer; 3) Other cancers – treatment for pain, anti-vomiting medication, osteolytic treatment of metastases, neuropenia; 4) Epilepsy; 5) Epilepsy resistant to treatment; 6) Schizophrenia resistant to treatment; 7) Parkinson’s disease; 8) Myasthenia gravis; 9) Wilson’s disease; 10) Alzheimer’s disease; 11) Lateral sclerosis; 12) Acromegaly; 13) Mucoviscidosis; 14) Deficiency of the thalamus of somatotropic nature; 15) Diabetes mellitus; 16) Phenylketonuria; 17) Celiac disease; 8) Myxedema; 19) Bed wetting in

⁸ In fact there is common practice, however, that patients admitted to hospitals and other stationary health care centers are “asked” to bring their own drugs sometimes, especially when the drugs are expensive and are used also in ambulatory care, which means they are available in regular pharmacies.

children; 20) Ulcerative colitis and Crohn's disease; 21) Osteoporosis; 22) Benign prostatic hypertrophy; 23) Coronary disease and post-infarction state; 24) Glaucoma; 25) Asthma and chronic lung disease; 26) Rheumatic disease; 27) Psoriasis; 28) Chronic ulceration; 29) Tuberculosis; 30) Critical insufficiency of blood circulation in the limbs; 31) One drug is also specified: highly purified insulin for insulin-dependent diabetes, pregnancy, and other conditions with an absolute indication.

It is characteristic that patients belonging to the group of war and military victims, who were entitled to *any* drug prescribed by a physician without charge made up for only 0.3% of total population of Poland and consumed 10% of total Sickness Funds drugs reimbursement in 1999⁹.

In cases when the above mentioned rights do not apply, even the "basic drugs" are reimbursed only to the limit of the price fixed by the Ministry of Health. Also, some drugs for chronically ill patients are not completely free of charge, but are paid at a fixed amount or a portion of the market price. All drugs on the basic and complementary drug lists have a reference price, which means that their level of reimbursement is referred to the cheapest equivalent available on the market in the particular therapeutic category.

Drugs on the basic list are reimbursed at a flat fee (fixed amount) equivalent (in theory) to 0.05% of the minimum wage¹⁰(referred to "reference price"). However, the currently applied amount of 2.5 zlotys has not been raised for some time which makes it considerably lower compared to the time it was introduced.

On the supplementary drug list, in the case of generic drugs, the price of the least expensive product is considered the reference price. In the case of "internationally available drugs", the price is set on the basis of the cheapest drug available. If a drug is available from the Polish pharmaceutical industry at a very low price, for example, prescription of a brand name product for quality or other reasons often results in the patient receiving only a very small fraction of the drug price. This was, however, another important mechanism which limited the growth of prices for reimbursement drugs before the "law on prices"¹¹ was implemented in 2001.

According to law, the wholesale and retail prices for drugs produced in Poland were set by the Ministry of Finance in Zlotys. On the other hand, drugs only available internationally were paid on a negotiated basis in the currency of the producer. The resulting system has many inequities and is not transparent. The "law on prices" had changed the procedure and linked the setting of prices for pharmaceuticals with reimbursement decisions. The law was intended to refer all responsibility related to pricing and reimbursement to the Ministry of Health. The differences between domestic and imported drug prices were abolished this way and the Minister of Health obtained a very powerful tool in his hand, which allowed him to intervene in such a tangible issue as prices. The procedure of drafting the reimbursement list and price setting is made simultaneously; cost-effective considerations should have been introduced.

⁹ Data from Krajowy Związek Kas Chorych 2001

¹⁰ European Observatory on Health Care Systems, 1999

¹¹ ustawa z dnia 5 lipca 2001 r. o cenach (Dziennik Ustaw nr 97, poz. 1050) (art.5)

However, along with an evaluation effort made by a team contracted from *La Revue Prescrire*, a French medical journal specialized in the assessment of pharmaceuticals¹², the reimbursement lists were not based on any priority decisions that can be deduced from examining them. Experts looking for the medical rationale behind the list existing in Poland until 2002. For example, the drugs that were fully reimbursed should presumably be the most necessary. In addition, drugs might be placed on list 2 or 3, if they were perceived as being subject to abuse or too costly. Although many of the drugs on list 1 did meet this test, others failed to do so. Thus, the oldest and cheapest of anti-hypertensive drugs were on list 2, while beta-blockers, which were more expensive and were not the first line treatment, appeared on list 1. Plenty of drugs were placed on the lists although they had no known efficacy, e.g., vasodilators, treatments for functional gastrointestinal disorders, treatments for diarrhea, and drugs for pulmonary complaints.

Another important legal standard applying to drugs is that pharmacists are required to provide the cheapest available drug (generic) to a patient despite of what the prescription may specify. As noted, the payment level from the Sickness Fund is also related to the price of the cheapest drug.

Indeed, new decrees with renewed drugs lists were issued in March 2002¹³. The process of completing the lists became the focus of media attention. As a result, the former Minister of Health (Mr Lapinski) was a frequent guest of journalists trying to explain the reasons and rationales standing behind his decision of placing or not placing a certain drug on the list. He declared the appointment of a “*confidential*” groups of experts who were intended to be unreachable for pharmaceutical industry lobbyists¹⁴ and who were assigned the task of defining the reimbursement lists. Heated public discussions warmed up. On one side there was the Minister with his unperturbed and often provocative public statements, on the other stood various groups of interest, ranging from patients, sometimes backed up by pharmaceutical industry to pharmacists and physicians. Both sides offered conflicting predictions regarding the financial and social implications of the change. The governmental argued the process would save almost PLN 1 billion a year in Sickness Funds budgets while its opponents claimed that not only would it not save any money but it will even increase out-of-pocket expenditures of patients.

Generally, the drafting of the reimbursement lists in 2002 was marked by a series of conflicts and the whole procedure remained unclear. Minister Lapinski himself used to say that he made his decision on the basis of a declaration by pharmaceutical manufacturers regarding drugs market prices faxed to his office. The public perceived the process as an unclear battle of groups of interest. Simultaneously some experts called to use proved mechanisms of public tenders to determine which of competitive drugs should be placed on reimbursement lists.

¹² “Standard of health services purchased in the national health insurance system” (contract nr. 3.4.1.41), WB Project number 011.41053

¹³ Rozporządzenie Ministra Zdrowia, z 26 marca 2002 r. w sprawie wykazu chorób oraz wykazu leków i materiałów medycznych, które ze względu na te choroby mogą być przepisywane bezpłatnie, za opłatą ryczałtową lub częściową odpłatnością (Dziennik Ustaw nr 28, poz. 273), Rozporządzenie Ministra Zdrowia, z 26 marca 2002 r., w sprawie wykazu leków podstawowych i uzupełniających oraz wysokości odpłatności za leki uzupełniające (Dziennik Ustaw nr 28, poz. 272).

¹⁴ See: statements presented in “Służba Zdrowia” nr 23-25 (3119-3121); 21-31 march 2002,

Definitions of entitlements and benefits by sector – the social insurance sector

Medical rehabilitation services financed by the Social Insurance Institution (SII) (in Polish - ZUS)

The Social Insurance Institution finances activities which focus on prevention of disability pension, pursuant to the Act on social insurance system (articles 55, 57, 69) of 13/10/1998 and the regulation of specific principles and the process of referring to medical rehabilitation by the Social Insurance Institution and purchasing rehabilitation services as of 12/10/2001.

All insured persons covered by compulsory or voluntary pension and disability pension insurance are entitled to medical rehabilitation financed by the Social Insurance Institution (SII).

The Social Insurance Institution provides the disability pension prevention, including:

- 1) medical rehabilitation for insured persons endangered with complete or partial loss of work capacity or people on temporal disability pension
- 2) analysis of causes of incapacity to work
- 3) other preventive measures.

In the area of disability pension prevention the Institution:

- 1) refers insured persons to rehabilitation centers,
- 2) is allowed to establish and manager its own rehabilitation centers,
- 3) purchase rehabilitation services in other rehabilitation centers,
- 4) does research and analyses of causes for loss of work capacity,
- 5) is allowed to order and purchase research on causes for incapacity to work and methods of their prevention
- 6) is allowed to finance other activities related to disability pension prevention.

All activities associated with referring insured persons to medical rehabilitation in disability pension prevention and purchasing services are regulated by specific principles and patterns for referring to medical rehabilitation by the Social Insurance Institution and purchasing rehabilitation services as of 12/10/2001.

The need for rehabilitation services after the managing doctor fills the referral form for an insured or disabled person is further evaluated by the special assessing doctor working for the Social Insurance Institution. The application to medical rehabilitation is handed over to a local branch of SII by place of residence of the insured. An SII assessing doctor may require any clarification or further information from the referring doctor (mainly medical records) as well as from the insured person. The final decision is then announced. The SII assessing doctor may decide on the need for medical rehabilitation while he/she assesses the case of work incapacity or after reviewing the case of temporary incapacity to work due to illness. Also, during the process of issuing a medical certificate, an extension of the sickness benefit may be granted. The SII assessing doctor issues the decision on the insured or disabled person's need for medical rehabilitation in view of the latter regaining work capability as a result of rehabilitation.

While evaluating these options, the SII assessing doctor considers especially:

- 1) the type and the course of disease and its impact on the functional state of the body,
- 2) the degree of acquiring anatomical deficiencies, disability, effects of the disease.

- 3) the age, occupation, performing tasks and work conditions.

The SII assessing doctor's decision on medical rehabilitation need serves as a reason for referring the insured or disabled person to medical rehabilitation. The SII may refer the person to its own rehabilitation centers or any other center with the appropriate profile of services.

Medical rehabilitation in a rehabilitation center should last 24 days. This period can be extended or shortened by the head of the center, subject to SII's consent, in case of:

- 1) good chance for regaining work capacity in the extended period of rehabilitation,
- 2) early regaining of work capacity,
- 3) any other cause related to the insured or disabled person.

The SII covers the total costs of medical rehabilitation, including accommodation, full board, travel from the place of residence to the rehabilitation center and back. Travel expenditures are reimbursed to the level of the ticket price for the cheapest means of public transportation, taking into account any reduced fares.

Despite the physical rehabilitation, the medical rehabilitation for disability pension prevention includes also psychological rehabilitation, health education, learning of dietary precautions and health prevention, which comprise one of the strategic aims of the National Health Program for 1996-2005 (aim number six).

Lately, the SII has been cooperating with 39 rehabilitation centers providing medical rehabilitation of people with the aforementioned conditions. According to agreements with centers, the SII had at its disposal:

- 3,000 beds for insured persons with musculoskeletal disorders,
- 850 beds for insured persons with disorders of the cardiovascular system,
- 200 beds for insured persons with disorders of the respiratory system,
- 26 beds for insured persons with psychosomatic disorders

Medical rehabilitation services financed by the Agriculture Social Insurance Institution (ASII) (Polish acronym - KRUS)

The system of social insurance of farmers and their families is regulated by the Act on Social Insurance of Farmers and their families as of 20/12/1990 with further amendments.

The law provides a comprehensive list with the cases in which farmers and their family members can be eligible for agricultural social insurance. The new regulation, adopted in May 2004, enumerates the necessary conditions that have to be met in order to be covered by agricultural social insurance while maintaining a non-agricultural private enterprise.

The Act on Social Insurance of Farmers has regulated the issue of medial rehabilitation of all persons insured in the ASII and their families. The ASII undertakes necessary actions in order to help those insured persons who are incapable to work on a farm, yet, are likely to regain this capacity through treatment and rehabilitation or those endangered with incapacity for farm work.

These actions include:

- Referring to medical rehabilitation provided in rehabilitation centers
- Running medical rehabilitation centers

Supporting the development of outpatient rehabilitation services in rural areas
Doing research on causes of work incapacity
Sponsoring such studies as well as studies on work incapacity prevention.
Health promotion
Preventive actions in rural areas.

The ASII may also support insured persons for providing rehabilitation for their family members.

At the time this report was being drafted, there were no precise guidelines on the conditions of referring to medical rehabilitation and purchasing rehabilitation services. However, this is expected to be elaborated in terms of the following issues:

indication for rehabilitation and assessment of needs,
durability and periodicity of complete work incapability and its causes
age of applying person
terms and conditions for application for rehabilitation
manner of the travel costs reimbursement.

Nonetheless, all insured farmers may benefit from medical rehabilitation. It is organized in the form of a 21-day stay in ASII's rehabilitation centers and cooperating centers. The main aim of such rehabilitation is disability prevention or limitation of disability to the level enabling continuation of farm work. In case of persons with work incapability the aim is to enable them to regain the capacity lost by providing treatment and rehabilitation.

If the family members of the insured person are entitled to family allowance they can also apply for medical rehabilitation services. Other persons have to be covered by injury, sickness and maternity insurance for the preceding 12 months. Moreover, the ASII organizes holiday rehabilitation stays for farmers' children.

The general rule in the procedure for referring to medical rehabilitation is that such a service can be utilized only by persons under 55 (some exceptions apply), once in 24 months. However, those with permanent work incapability with a disability pension may utilize rehabilitation once every year. In single cases, where there is medical relevance for further rehabilitation the referral waiting time may be shortened and the rehabilitation period extended.

The utilization of rehabilitation services financed by ASII does not exempt farmers from utilizing spa treatment within the scope regulated by general health insurance. In summary, more than 14,000 people utilize medical rehabilitation services through the ASII. Since 1992, one of the agricultural rehabilitation centers in Iwonicz has served almost 120,000 patients. There is also a possibility to continue the rehabilitation process in outpatient settings.

Definitions of entitlements and benefits by sector – the rescue system

There are two laws regulating this system:

- Law of 25/07/2001 on National Medical Rescue Service (Letter of Issue No 113, pos. 1207 with lower changes 13)
- Law of 6/12/2002 on providing medical rescue service (Letter of Issue No 241, pos. 2073 and from 2003 No 99, pos. 920).

The Law on National Medical Rescue Service has brought to life a system called National Medical Rescue Service, which aims to guarantee proficient and effective realization of state's assignments related to medical rescue operations towards every person in a state of emergency, i.e., when any postponement of medical assistance could cause loss of health or loss of life.

In confines of medical rescue operations taken by unit of medical rescue service, the so-called health pre-hospital services are provided.

According to Art. 4. of the Law under discussion, the system of first-aid services includes executed of various assignments depending in particular on:

- 1) the possibility of making an immediate call for help using means of communications
- 2) the immediate arrival of medical rescue service unit on location
- 3) the immediate taking of proper medical rescue operations on location
- 4) organizing of transportation which is suitable to needs
- 5) organizing immediate admission to the closest hospital or emergency or hospital ward proper to the kind of emergency

According to Art 34. 1, health pre-hospital services are funded from the state budget from the part under disposition of the proper governor (regional delegate of central government), on the basis of contracts concluded with units' administrators (units of medical rescue services).

These services are funded using a flat round-the-clock rate.

2. Health pre-hospital services provided by air ambulance service units are funded from the state budget from the part under disposition of the minister proper to the medical case, on the basis of contracts concluded with units' administrators.

3. Health pre-hospital services provided by air searching and rescuing units are funded from the state budget from the part under the disposition of the Minister of National Defense.

4. The expenditures for providing the health service in confines of medical rescue operations, with exception of health services provided to the people not covered by common health transportation expenses and providing services on location and inside the means of transport insurance, are paid by the National Health Fund.

Act on providing medical rescue service of 6/12/2002 defines medical rescue service providing units and the rules for financing them. Medical rescue services are operations offering help in rescuing people in emergency state which are provided by the following units:

- 1) hospital rescue units
- 2) medical rescue units, including air ambulance service
- 3) centers of emergency information.

The principles of funding the health services provided in confines of medical rescue services are defined by the regulations on health care services funding from public resources. The National Health Fund concludes contracts for providing health care services in hospital rescue

wards and through medical rescue units included in the National Medical Rescue Service system.

The principles of funding these services were defined in the Regulation of the Minister of Health of 7/05/2003 on detailed conditions of funding health services provided in hospital rescue ward and unit of medical rescue service (Letter of Issue No 103 of 2003, pos. 961).

Definitions of entitlements and benefits by sector – mental health and substance abuse

Mental health and substance abuse therapy are regulated by the following laws:

- of 19/08/1994 on mental health's safety (Letter of Issue No 111, pos. 535, with lower changes 11)
- of 24/04/1997 on counteracting drug addiction (Letter of Issue of 2003 No 24, pos. 198 and No 122, pos. 1143);
- of 26/10/1982 on education in sobriety and alcoholism counteracting (Letter of Issue of 2002 No 147, pos. 1231, with later changes)

According to the Act on mental health, health services provided to mentally sick or handicapped people by health care public institutions are without charge. Medicines, sanitary supplies, accommodation and catering which are appropriate to the health status are free of charge for patients staying in public mental hospitals.

According to par.5, health care for people with mental disorders includes both basic and specialist care, in particular psychiatric health care – in the form of instant, ambulatory, daily, hospital, and environmental help and in social homes. According to par. 12, in selecting the type and method of health care, not only health objectives are taken into consideration but also other personal benefits to the patient, the goal being to achieve improvement of the health status in the least onerous way. The utilization of the treatment is voluntary, subject to the patient's consent although in special cases the so-called "direct compulsion" can be used.

According to par. 18, direct compulsion towards people with mental disorders can be applied only in case of actions threatening the person's own life or health, the life or health of other people, public safety or violent destruction of objects or in other specific cases defined in the act. Direct compulsion is decided by a physician who determines the method to be used and personally supervises the process.. For patients residing in mental hospital or in social homes, when the doctor's decision is impossible, the decision may also be taken by a nurse, who is obligated to notify the doctor immediately. Every instance of direct compulsion is reported in medical documentation. Direct compulsion includes holding, enforced application of medicines, immobilization or isolation. Persons whose behavior indicates it can be harmful to their own life or the lives and health of others, or who are not able to fulfill basic life needs due because of mental disorder, can be referred to psychiatric examination without their consent or of their legal representative (in case of a juvenile or a totally incapacitated person). Then, par. 18 on direct compulsion takes effect.

Pursuant to the Act on counteracting drug addiction, people addicted to narcotics or psychotropic agents can receive free treatment, rehabilitation or participate in a program of reintegration run by centers for social integration (par. 14 of act 6). The above services are provided by health care institutions regardless of the addicted person's permanent place of residence. Treatment and rehabilitation provided by a health care institution or by doctor running an individual practice. Rehabilitation of addicted persons can also be provided by

specialists with high non-medical education; people who have at least secondary education can participate in the rehabilitation process, if they have completed a specialist courses in the area of addictions, according to a program approved and certified by the minister of health.

Addicted persons can be treated by means of a substitutional (e.g. metadon) therapy (par. 15) which can be offered only by public health care institutions, after receiving permission from the governor acting in cooperation with the minister proper to health cases.

Addicted person may receive treatment or rehabilitation on a voluntarily or forceful basis. According to par. 17. on proposal of legal representative, straight line relatives, siblings or actual care-giver or from office, familial court can direct addicted person, younger than 18 years old, onto enforced treatment and rehabilitation.

On the basis of the Act on education in sobriety and counteracting alcoholism, people addicted to alcohol are exempted from payments for disaccustoming treatment provided in health care institutions (par. 21).

Family members of a person addicted to alcohol affected by the consequences of alcohol abuse receive therapy and rehabilitation of co-addiction and its preventing in public health care institutions of. These services are free of charge for the categories of people mentioned above. Children of people addicted to alcohol affected by the consequences of alcohol abuse of their parents receive psychological and psychotherapeutic help free of charge in public health care institutions, public specialist clinics or in protective educational and reclaiming facilities. Children may receive such assistance in spite of the disagreement of their addictive parents or trustees.

The disaccustoming treatment for alcohol abuse is offered by inpatient and outpatient facilities designated for this purpose or by health care institutions. Submission to disaccustoming treatment is voluntary. However, there are exceptions from this rule. According to par. 24, alcohol abuser causing decomposition of family life, corruption of minors, evade professional duties or systematically disturb peace or public order should be referred to an examination for issuing a statement and prescribing therapy in an appropriate institution. If found addicted to alcohol, such persons can be coerced to submit to disaccustoming treatment in inpatient or outpatient facility. Compliance to such obligation is ruled by the regional court by place of residence or stay.

Definitions of entitlements and benefits by sector – infectious diseases

The Act on infectious diseases and infections of 6/09/2001 (Letter of Issue No 126, pos 1348, with later changes) – in case of health services related to actions against infectious diseases and infections;

The act on infectious diseases and infections is an important legislative document that introduces actions aiming at safety of life and health not only of individuals but of the community as well. This act contains regulations and provisions regarding the mode of conduct in terms of preventing and overcoming infectious diseases and infections in people and, in particular, of recognition and surveillance of the epidemiological situation and taking anti-epidemic and preventing actions for removing the source of infection and eliminate spreading, including those that affect immunity (par. 1).

Persons staying in the territory of the Republic of Poland are subjected to the provisions of par.5, in particular. Pursuant to the provisions of this act, they are obligated to:

- 1) submit to examinations that intend to detect infections and infectious diseases, including also submitting to treatment that intends to take or deliver material to these examinations
- 2) submit to mandatory preventive vaccinations
- 3) submit to mandatory treatment, mandatory hospitalization, isolation, quarantine and epidemiologic supervision
- 4) provide information that is essential to infectious disease prevention.

The obligation for vaccination does not concern people staying in the territory of the Republic of Poland for a period of time shorter than three months, except for vaccinations against rabies and tetanus of people suspected for being infected.

According to par. 6, in order to ensure sanitation and public health, the following groups of persons must be tested:

- 1) pregnant women who were exposed to HIV as well as newborns of mothers infected with HIV or treponema – for these infections
- 2) people who were exposed to infection through contact with infected people or infectious material – for diphtheria, cholera, dysentery, typhoid, A, B and C paratyphoid fevers, anterior poliomyelitis
- 3) people who carry or convalesce after diphtheria, cholera, typhoid, A, B and C paratyphoid fevers, salmonellosis, and dysentery caused by Shigell's rod – for state tests
- 4) people taking up or performing work associated with a possibility of transmission of infection to other people – intending to identify the infection with tubercle bacillus, Salmonella typhi, A, B, C Salmonella paratyphi and other rods of Salmonella Shigell's type, and also intending to identify the existence of other pathogenic agents determined in a list to be elaborated by the minister of health in a regulation)
- 5) pupils and university students who study for performing jobs associated with a possibility of transmission of infection to other people (according to a relevant regulation of the Minister of Health) – intended to identify the infection with tubercle bacillus, Salmonella typhi, A, B, C Salmonella paratyphi and other rods of Salmonella Shigell's type, and also intending to identify the existence of other pathogenic agents determined in a list mentioned in pt 4).

The examinations and tests mentioned in pt 1 and 2 are performed by a provider, who has concluded contracts with the National Health Fund for providing these health care services. The examinations' costs of insured people are funded on the basis defined in health insurance regulations. However, the costs of uninsured people are covered from the state budget, from the part under disposition of the minister proper to health care.

There are examinations described in pt 4 which concern employers who are obliged to notify their employees and also bear the costs. The cost of the examinations referred to in pt 5 are paid by the respective units of local government from resources designated for such purposes.

An important element of warding off the infectious diseases is the program for executing preventive vaccinations, i.e., mandatory and recommended. Mandatory vaccinations of insured people are executed by providers who have concluded contracts for providing these services with the National Health Fund; reimbursement is defined in insurance regulations.

However, if an insured person has a mandatory vaccination performed by another provider than defined by law, the cost is not subject to reimbursement. Mandatory vaccinations of uninsured people are funded from the state budget, from the part under disposition of the minister of health (par. 16).

In view of preventing the spread of infectious diseases among workers who are exposed to biological agents are entitled to preventive vaccinations identified for specific job positions (par. 17). The list of these positions is included in the Regulation of the Minister of Health of 3/01/2003 on job positions and preventive vaccinations to be performed on people holding such job positions or about to take them (Letter of Issues No 5 of 2003, pos. 60). Employers are liable to to inform the employees about the type of vaccination denoted. Employers also bear the costs of preventive vaccinations and for preparations for such vaccinations.

The list of vaccinations recommended for certain groups of people in relation to age, health status, epidemiologic situation in a given area and vaccinations based on other countries' requirements and World Health Organization's recommendations is announced by the minister proper to health cases by proclamation (par. 18.) The cost of the vaccinations recommended is covered by the person vaccinated.

The preventive vaccinations of insured people are performed by providers who have concluded contracts for these services with the National Health Fund. The provision of these vaccinations is funded by the state budget, except for vaccinations performed in connection with a trip abroad (which are paid by the traveller).

If an insured person receives a recommended vaccination performed by a provider different from the ones defined by law, the cost is payable by the person. The cost of recommended vaccinations provided to uninsured people is covered by the latter.

If as result of vaccination an undesirable post-vaccinal reaction appears, then treatment of insured people is pursued as defined in health insurance regulations. The cost of treating uninsured people for undesirable post-vaccinal reactions is covered from the state budget from the part under disposition of the minister of health.

A separate group of services comprise the care provided to people returning from abroad sick or reasonably suspected of being contagious (par. 27). These people can be submitted (have the obligation to submit) to examinations intended to detecting infections and infectious diseases as well as to mandatory treatment or hospitalization, isolation, quarantine or epidemiologic supervision, as per par. 23 of Act 1 (that is, by administrative decision issued by the proper sanitary inspector).

According to par. 29, the health care services mentioned above provided to insured people are reimbursed on the basis of health insurance regulations while those provided to uninsured people are paid from the state budget from the part under disposition of the minister of health.

The last group comprises services provided to people with pulmonary tuberculosis (par. 31) who are liable to mandatory ambulatory treatment. Fulfilling this duty involves submission to a medical check-up and other diagnostic tests as well as to the treatment prescribed. Health care service in this case include administration of drugs as well.

The cost of care provided to insured people with tuberculosis is funded pursuant to health insurance regulations while the expenditures of uninsured people are reimbursed from the state budget from the part under disposition of the minister of health.

The Regulation of the Minister of Health of 18/04/2002 on the mode of funding from state budget the expenditures of health care services provided in connection with infectious diseases and infections is applicable (Letter of Issues No 63 of 2002, pos. 577) to all health care services associated with infectious diseases provided to uninsured people are funded from the state budget, from the part under disposition of the Minister of Health,.

Definitions of entitlements and benefits by sector – prisoners and foreigners under care of the State

Health care for prisoners and foreigners staying in close centers under care of the State are regulated by two laws:

- Executive Penal Code of 6/06/1997 (Letter of Issue No 90, pos. 557, with later changes
- Law on foreigners of 13/06/2003 (Letter of Issue No 128, pos. 1175 and, of 2004 No 96, pos. 959 and No 179, pos 1842)

Under the penal code, convicted persons staying in prison (imprisoned person), have are entitled to:

- health care services related to health prevention (par. 102, pt1)
- complementary health care services, medicines and medical supplies (par. 115 § 1).

Paragraph 115 contains a detailed provisions on the rules of providing and funding health care services to convicts, e.g.:

- in accordance with § 1a, an imprisoned person does not have the right of choosing primary care provider, ambulatory care provider, dental care provider or inpatient care provider or facility as defined in the Act on health care services funded from public resources of 27/08/2004 (Letter of Issue No 210, pos. 2135)
- in accordance with § 2, prostheses, orthopaedic items and medical appliances are provided to imprisoned persons free of charge, if the health status of the latter can worsen as a result of their absence or imprisonment be hindered; in other cases they should be paid for,
- in accordance with § 4, health care services are provided to imprisoned persons by the prison health care facility first,
- other health care institutions cooperate with prison health care facilities (§ 5) in order to guarantee the provision of necessary health care services to convicts, in particular:
 - 1) instant provision of health service in case of situations of life threatening or of severe health deteriorating nature.
 - 2) consultations with a specialist, treatment or rehabilitation
 - 3) provision of health care services to imprisoned persons who have permissions or a temporary permission to leave the reforming institution
- in accordance with § 6, the penal institution's governor, after receiving the opinion of the penal institution's doctor may allow in exceptional cases that the imprisoned person use additional medicines and other medical resources.

The act on foreigners contains provisions that grant foreigners placed in guarded centers or in detention for the purpose of expelling authorization to receive free health care (par. 117). Foreigners have the right to health care services, including admission to hospitals, if case of

medical indications. Foreigners accommodated in guarded centers or in detention for the purpose of expelling must have a medical examination (par. 113) or sanitary treatment, if needed. Physicians providing health care services to foreigners in guarded centers or in detention for the purpose of expelling must maintain documentation according to certain rules. The above costs are reimbursed from the state budget, from the part under disposal of the minister of the interior.

Foreigners placed in guarded centers or in detention for the purpose of expelling receive health care services, medicines, sanitary articles and meals, according to rules applied in relation to people placed in penal institutions and in custody, on the basis of the Executive Penal Code (par. 118).

The regulations on the provision of health care services to foreigners are incorporated in the act on health care services funded from public resources.

Definitions of entitlements and benefits by sector – occupational medicine

Legal principles of granting evidence in the field of occupational medicine.

The obligation for providing services and goods to employees is a result of art. 229 of the Code of Labor (Act of 26/06/1974. Code of Labor – uniform text: Letter of Issue No 21 of 1998, pos. 94 with later changes). Besides, the Code of Labor stipulates a number of other duties connected with employees' health care, *inter alia*, prevention of work accidents and occupational diseases, as well as provision of care to pregnant women and working youths.

The fundamental law, which specifies the goal and general rules of preventive care for employees is an Act on occupational medicine services of 27/06/1997 (Letter of Issue No 96, pos. 593). This act took effect on 1/01/1998 and defined an important branch of health care, creating the so-called occupational medicine. It focuses on health care of employees which aims against the effects of adverse conditions in the working environment or work processes, as well as on preventive health care.

The Code of Labor, which serves as the basis for the prevailing part of assignments of occupational medicine, is implemented through a Regulation on medical examinations of employees, the range of preventive health care and medical statements, issued for the purposes provided in Code of Labor (Letter of Issue No 69 of 25/06/1996, pos. 322) adopted by the Minister of Health of 30/05/1996).

A separate group of assignments, which the Code of Labor does not interpret as having preventive nature, are realized by occupational medicine, i.e., sanitation inspections and public health measures. Their scope is regulated by separate rules issued under the provisions of in art. 6 of the Act on infectious diseases and infections of 06/09/2001 (Letter of Issue No 126 of 2001, pos. 1384 with later changes)

Another group of tasks performed by occupational medicine includes medical examinations of drivers and of persons applying for a driving license . Based on par. 123, the Minister of Health issued a Decree of 7/01/2004 on examinations of drivers and of persons applying for a driving license (Letter of Issue No 2 of 2004, pos. 15). Furthermore, par. 124 of the preceding act refers to an obligation of performing psychological tests in certain cases in order to verify drivers' psychical predisposition.

In accordance with par. 2 pt 3 of an Act on occupational medicine, the organizational units are as follows:

a/ basic units:

- × public health care institutions providing preventive care to employees
- × health care institutions providing established and maintained by employers and other entities, if the provision of preventive care to employees is their designated scope of activity
- × individual practices

b/ provincial centers of occupational medicine.

The obligations of occupational medicine service are fully discussed in art. 6 of the law:

- × Eliminating the harmful influence of the working environment on health, in particular by:
 - Recognizing and estimating the factors of the working environment and work performance, that could have negative influence on health
 - Recognizing and estimating occupational risk in the working environment and informing employers and employees about possibilities of resulting adverse effects
 - Advising employers and employees about work organization, ergonomics, physiology and work psychology.

Employers' duties are defined as performing preventive care to employees, in particular:

- a) performing initial, regular and follow-up medical examinations provided for in the Code of Labor,
- b) medical certification for the purposes provided for in the Code of Labour and the regulations issued on its basis,
- c) estimating capacity for work or health status and assessing hazards in the working environment ,
- d) managing counseling, diagnostics and certification related to occupational pathology,
- e) managing active counseling in relation to occupational diseases or other diseases connected with performing work,
- f) providing vaccinations, mentioned in art. 17 of the act on infectious diseases and infections of 6/09/2001 (Letter of Issue No 126, pos. 1384, 2003 No 45, pos. 391 and nr 199, pos. 1938 and from year 2004 nr 96, pos 959),
- g) monitoring the health status of the working population divided into specific risk groups, especially people performing work in violation of hygienic norms, youths, disabled and women in reproductive age and pregnant women,
- h) performing examinations which enable early diagnostics of occupational diseases and other diseases connected with the work performed;
- i) managing outpatient rehabilitation motivated by affirmed occupational pathology,
- j) organizing and dispensing first medical aid in sudden illnesses and accidents, which appeared in place of work or study;
- k) initiating and realizing health promotion, especially pro-health programs resulting from workers' health assessment;
- l) initiating activities in favor of health care provision to employees and assisting its realization, especially in the range of:
 1. informing employees about the rules of reducing occupational risk
 2. introducing health prevention rules among workers falling under high risk groups
 3. creating conditions for providing occupational rehabilitation
 4. initiating health promotion programs
 5. organizing the provision of first aid

- m) managing employees' health status analyses, especially in relation to occupational diseases, their causes and causes for work accidents;
- n) compiling, storing and processing information about hazardous exposure, occupational risk and health status researched by preventive health care programs.

Additionally, some employee groups have their own regulations regarding occupational medicine, which reflect work or service specificity.

Regulation of the Minister of the Interior and Administration of 25/09/2001 on the activities of occupational medicine offices (Letter of Issue No 118 2001 pos. 1270) contains the following provisions:

To duties of occupational medicine services include:

- 1) performing preventive health care, through:
 - a) preventive examinations – regular, follow-up for civil workers, issuing statements on health status by physicians at the place of work
 - b) providing vaccinations in relation to the work performed
 - c) providing psychological prevention related to post-traumatic stress;
- 2) analysis of work conditions pertaining to emission of harmful and onerous agents, in particular exposure to:
 - a) irritating substances, allergenic, carcinogenic, toxic substances, infectious agents and dusts
 - b) negative atmospheric influence
 - c) long-term state of emotional tension
 - d) contact with explosives and inflammables
- 3) offering education and guidance to employers and employees related to organization of work, ergonomics, physiology and psychology;
- 4) providing psychological counseling and prevention of problems resulting from stress and its consequences;
- 5) identifying danger of diseases and organizing preventive activities, including vaccinations for officers and workers leaving the Republic of Poland;
- 6) assessing and referring officers and government workers to preventive rehabilitation and anti-stress periods;
- 7) offering regular education in the field of prevention and health promotion in consideration of occupational risk caused by emotional tension;
- 8) organizing first aid in sudden cases of disease or accidents at the places of service, work or study, therein during:
 - a) managing operations and education in pyrotechnics and chemical substances;
 - b) tests and professional training courses
 - c) training and activities of officers exposed to high risk of injury; taking immediate interventions
 - d) actions undertaken in view of imposing order and public safety at mass entertainment and other events.
- 9) gathering, storing and processing information about occupational risk and health status of people covered by preventive care and delivering relevant statistical data after deleting confidential personal data to the General Director of the Office for Repatriations and Aliens, the Director of Government Security Bureau, the Chief Commander of Police, the Chief Commander of State Fire Service and the Chief Commander of Border Guards.

Regulation of the Minister of National Defense of 15/06/1999 on the activity of occupational medicine offices in organizational units subordinated to or supervised by the Minister of National Defence (Letter of Issue No 61 from year 2001 pos. 665 with later changes), where § 4 refers to the following:

The duties of occupational medicine offices include:

- 1) identifying, analyzing and counteracting the health threats of soldiers on duty at naval units of the Polish Navy,
- 2) cooperating with navy commanders in order to guarantee conditions of service which eliminates negative influence on soldiers' health, especially connected with long-term stay on the sea and, in case of submarines, – with staying in submergence,
- 3) providing prevention for the flying staff of the Polish Armed Forces with special consideration of health care for soldiers flying under the influence of G-force.
- 4) guaranteeing specific health care to soldiers working as divers or parachutists, and also to equipment operators in rocketry and air force units
- 5) identifying sickness threats and providing prevention, vaccinations therein, to soldiers and army workers leaving the Republic of Poland and after their return, and also providing health care during the time of their stay
- 6) eliminating health threats connected with transitory army camping, especially in case of military alert.

Regulation of the Minister of Justice of 29/05/2003 on the activities of occupational medicine offices related to the elimination of the specific occupational risk in organizational units of Prison Services (Letter of Issue No 105 of 2003 pos. 992) whose § 1 and 2 provide the following:

The duties of occupational medicine offices include:

- 1) provision of preventive care through preventive examinations, i.e. regular and follow-up
- 2) assessment of work and service conditions in terms of emission of harmful agents, in particular exposure to:
 - a) chronic and traumatic stress caused by performing duties connected with detention, punishment and compulsion measures implicating imprisonment
 - b) influence of irritating, allergenic, carcinogenic, toxic substances and infectious agents
 - c) negative indoor air influence.
- 3) monitoring the health status of high risk groups, especially armed officers on duty or working in constant and direct contact with imprisoned individuals,
- 4) maintaining medico-psychological prevention to avoid the effects of disturbance after chronic and traumatic stress;
- 5) assessing and referring officers and workers to preventive care and rehabilitation during fitness camps
- 6) compiling, storing and processing information about the occupational risk and health status of people covered by preventive care and submit relevant statistical data to the General Director of Prison Services.

Regulation of the Minister of Transportation and Sea Economics of 28/06/1999 on the activity of occupational medicine offices related to the specific occupational risk of railway transportation workers (Letter of Issue No 61 of 1999, pos. 674) has the following provisions:

Tasks mentioned in relation to railway transportation workers include:

- × analyzing the requirements related to state of sight and hearing organs and psychophysical efficiencies indispensable for performing actions on certain positions in railway transportation, for the needs of standardization of preventive examinations,
- × providing the medical examinations which are indispensable for issuing medical certificates and psychological assessment according to the rules derived from occupational risk,
- × assessing and referring employees to spa-treatment institutions for preventive and remedial periods financed by employers
- × managing studies of the risk of mistakes that constitute a threat to public safety and cause a loss of capacity to work.

Occupational medicine offices conduct informational and educational activity with a focus on occupational risk and psychological counseling.

However, an additional group of assignments comprises medical examinations of drivers and persons applying for a driving licence. It is hard to separate drivers' examinations from occupational medicine as drivers form a professional group as well.

The method of financing benefits related to occupational medicine depends on the legal basis of given examination. If workers are examined for reasons provided for in the Code of Labor, the cost is covered by the employer. It results from par. 229, paragraph 6 of the Code of Labor as well as from par. 22 of the Act on occupational medicine offices:

“Par. 22. Employers:

- × bear costs of initial, periodical and follow-up examinations and preventive care required in view of work conditions, under the rules prescribed in the Code of Labor and the regulations issued with regard to its implementations.
- × fund the health benefits they have selected from the range of preventive care services pertinent to occupational medicine offices' assignments specified in par. 6 of an act 1 (author's note: these are assignments that allow a limitation of harmful influence of work conditions on health).

The cost of inspection related to sanitation and public health (in favor of persons employed in manufacturing industries and trade in food products) is borne by the employer.

The preventive care performed by occupational medicine offices is funded by the following entities:

- × self-employed persons and their business partners
- × individual farmers and working family members as well as members of agricultural production associations, excluding settlements related to agricultural occupational diseases the funding of which must be based on the rules stipulated in the regulations on farmers' social insurance,
- × former employees and persons who performed work on other basis than employment contract or persons who remained in business relations, unless not specified otherwise in other regulations.

The following local government activity is funded from resources deriving from grants,:

- × consultative, diagnostic and therapeutic activities related to occupational pathology
- × active guidance of persons suffering from occupational diseases or other diseases connected with the work performed

- × preventive vaccinations required for the work performed
- × outpatient rehabilitation justified by evidence of pathology
- × first aid in case of sudden illness or accident , which occur in place of work, service or learning
- × occupational medicine provided to candidates for secondary and high schools or universities, pupils of these schools and students exposed to harmful, irritating or life threatening agents during their professional studies, and also to students of medicine exposed to harmful, irritating or life threatening agents during profession studies; therein, first of all, assessing health status and possible threats in view of performing a certain job or studying .
- × preventive care performed to persons who work while serving time in penitentiaries, while placed under arrest for investigation, or during imprisonment, if the obligation to provide prevention is not borne by the employer.

The following types of activity is funded from local budgets resources:

- × activity of local centers of occupational medicine
- × preventive care resulting from pro-health programs related to prevention and counteracting certain diseases and implementing health promotion programs set by the Minister of Health or local governments
- × periodical medical examinations provided in view of par. 229, point 5 of the Code of Labor in case that the employer undergoes liquidation; it refers to workers exposed to carcinogenic substances and agents or dusts, who continue to be entitled to periodical medical examinations after the exposure stops and their employment contract is terminated, if they report the proposal to receive these examinations.

The activity of occupational medicine offices in in the “Polish National Railways” is financed from its own resources.

The activity of occupational medicine offices is conducted on the grounds of the following legal acts and is funded from the state budget:

- × Regulation of the Minister of National Defense on occupational medicine offices in the organizational units subordinated or supervised by the Minister of National Defense (Letter of Issue No 61 of 1999 pos 665 with later changes),
- × Regulation of the Minister of the Interior and Administration on occupational medicine offices in the department of the interior and administration (Letter of Issue No 3 of year 2000 pos. 42),
- × Regulation of the Minister of Justice on occupational medicine offices in the organizational units of Prisons (Letter of Issue No 138 of 2003, pos 1321).

Medical examination of drivers and of persons applying for a driving licence are provided paid out-of-pocket by the examined person or employer, if the person holds the position of (or acts as) a driver. However, the regulation of the Minister of Health of 7/01/2004 on medical examination of drivers and persons applying for driving licenses (Letter of Issue No 2 of 2004 pos. 15, § 18) defines the maximum rates for this kind of health care services.

Classification of social health insurance benefits

The Social Health Insurance Fund (NHF) covers fully or partially the services and goods listed in Table 7 by category. These services and goods are jointly called “products” and the whole document is called “the products catalog”.

Table 7. Products catalog of the National Health Fund of Poland mapped to System of Health Accounts functional categories.

NHF products	SHA category
<u>Primary care</u>	<u>HC.1.3.1 Basic medical and diagnostic services</u>
-	<u>HC.6.1 Maternal and child health; family planning and counselling</u>
-	<u>HC.6.2 School health services</u>
-	<u>HC.6.3 Prevention of communicable diseases</u>
-	
<u>Ambulatory care - surgical</u>	<u>HC.1.3.3 All other specialised health care</u>
<u>Ambulatory care - medical and diagnostics</u>	<u>HC.1.3.3 All other specialised health care</u>
<u>Ambulatory care - diagnostics</u>	<u>HC.4.2 Diagnostic imaging</u>
-	
-	
<u>Hospital care - general</u>	<u>HC.1.1 In-patient curative care</u>
<u>Hospital care - radiology, nuclear medicine</u>	<u>HC.1.1 In-patient curative care</u>
-	<u>HC.1.2 Day cases of curative care</u>
<u>Hospital care - oncological therapy</u>	<u>HC.1.1 In-patient curative care</u>
-	<u>HC.1.2 Day cases of curative care</u>
-	
<u>Hospital care - non-oncological therapy</u>	<u>HC.1.1 In-patient curative care</u>
-	<u>HC.1.2 Day cases of curative care</u>
-	
-	
<u>Dentistry - children</u>	<u>HC.1.3.2 Out-patient dental care</u>
<u>Dentistry - pregnant women</u>	<u>HC.1.3.2 Out-patient dental care</u>
<u>Dentistry - general</u>	<u>HC.1.3.2 Out-patient dental care</u>
-	
-	
<u>Spas</u>	<u>HC.2.1 In-patient rehabilitative care</u>
-	<u>HC.2.3 Out-patient rehabilitative care</u>
-	
-	
<u>Emergency</u>	<u>HC.4.3 Patient transport and emergency rescue</u>
-	
-	
<u>Separately contracted services</u>	<u>HC.1.2 Day cases of curative care (incl. Hemodialysis)</u>
-	
-	
<u>Psychiatric and substance abuse therapy</u>	<u>HC.1.1 In-patient curative care - mental</u>
-	<u>HC.1.3.3 All other specialised health care - mental</u>
-	<u>HC.1.2 Day cases of curative care - mental</u>
-	
-	
<u>Rehabilitation</u>	<u>HC.2.1 In-patient rehabilitative care</u>

-	<u>HC.2.2 Day cases of rehabilitative care</u>
-	<u>HC.2.3 Out-patient rehabilitative care</u>
-	<u>HC.2.4 Services of rehabilitative home care</u>
-	
-	
<u>Long term care</u>	<u>HC.3.1 In-patient long-term nursing care</u>
-	<u>HC.3.2 Day cases of long-term nursing care</u>
-	<u>HC.3.3 Long-term nursing care: home care</u>
-	
-	
<u>Health promotion & prevention</u>	<u>HC.6.4 Prevention of non-communicable diseases</u>
-	
-	
<u>Medical (incl. Orthopedic) products</u>	<u>HC.5 Medical goods dispensed to out-patients</u>
-	<u>HC.5.2.2 Orthopaedic appliances and other prosthetics</u>
-	<u>HC.5.2.1 Glasses and vision products</u>
-	<u>HC.5.2.3 Hearing aids</u>
-	<u>HC.5.2.4 Medico-technical devices, incl. wheelchairs</u>
-	<u>HC.5.1 Pharmaceuticals and other medical non-durables</u>
-	
-	
<u>Pharmaceuticals</u>	<u>HC.5.1.1 Prescribed medicines</u>

Taxonomy and nomenclature of benefits

The logic of products nomenclature reflects the way it is used for payment and monitoring purposes. The whole catalog is, however, not a universally organized; it is rather a set of sub-catalogs, which are published in different time intervals in different documents.

Some parts of the catalog are published in the form of legal acts and their appendixes, e.g.:

- Dentistry – children
- Dentistry - pregnant women
- Dentistry - general
- Spas
- Medical (incl. Orthopedic) products
- Pharmaceuticals

while others are developed fully by the National Health Fund experts.

Table 8. Catalog of benefits provided by the social health insurance fund (NHF)

Area	Method of payment
Primary care	care per member of population (per capita) per month
Ambulatory care - surgical	per procedure
Ambulatory care - medical and diagnostics	per visit (regardless of inclusions)

Ambulatory care - imaging diagnostics	per procedure
Hospital care - general	per admission (case)
Hospital care - radiology, nuclear medicine	per therapeutic cycle
Hospital care - oncological therapy	per therapeutic cycle
Hospital care - non-oncological therapy	per therapeutic cycle
Dentistry - children	per procedure
Dentistry - pregnant women	per procedure
Dentistry - general	per procedure
Spas	per therapeutic cycle
Emergency	per day of availability
Separately contracted services	Various
Psychiatric and substance abuse therapy	per episode (visit, day of care, admission)
Rehabilitation	per episode (visit, day of care, admission)
Long term care	per day of care
Health promotion & prevention	per patient enrolled
Medical (incl. Orthopedic) products	refund to certain limit
Pharmaceuticals	flat rate, refund of 70% or 50% of a drug

The terminology which was used in each part of the benefit package was little formalized. The only areas of the above catalog of benefits, which refer to formalized terminology, are the following:

- dentistry – the package, defined in a regulation of the Minister of Health, uses the terminology of procedures of the International Classification of Procedures – 9th Revision - Clinical Modification, Second Polish edition (1999). The procedures denoting various dental care procedures were, however, placed in the 1999 Classification by the Polish editorial board, what makes it incompatible with any other procedure classification in the World.
- Pharmaceuticals – names and codes are taken from the pharmaceuticals register permitted for sale in the territory of Republic of Poland,
- Ambulatory care – general and hospital care – general counseling visits were named from specialty of the ambulatory or department (internal medicine, surgery, etc), defined in the regulation of the Minister of Health on the system of health sector codes.

Decision-making process

Defining the benefit package in any area of health care, from social health insurance to occupational health, takes place in Poland in two general ways;

- legal – a two-level legislative process; the Parliament in case of laws and the Ministries of Government as refers to Regulations,
- administrative – through decisions of the National Health Fund administrative personnel of, as regards parts of NHF’s catalog.

The legal procedure is precisely defined as regards the parties, which are involved, in the decision-making process, although this procedure is universal for ANY legal documents, and is not restricted to the legal acts defining the benefit package.

The legislative process implemented in the following way:

- laws – virtually any group of persons may have, the so-called, legislative initiative and draft a bill. If a group of citizens decides to take this initiative, it has to collect 100,000 citizens signatures in support of the draft bill.

Generally, however, it is usually the Government that initiates drafting bills and legal amendments. It (i.e., the appropriate Minister) organizes a group of experts, supported by Ministry experts, including legal officers. The draft bill is reviewed in two phases before being referred to the Parliament where it is analyzed by the appropriate Parliamentary Commission and sometimes Sub-Commissions comprising the most interested members of the Commission. The Commission and sub-commissions invite experts to the meetings, who provide advice.

The bill drafted by the Commission is finally referred to Parliament for voting. The bill adopted by the Lower Chamber of the Parliament is forwarded to the Higher Chamber (the Senate), which can introduce changes. These changes may be accepted or rejected by the Lower Chamber (Sejm) and the bill is then passed on to the President, who has the right to a veto which is rarely used.

- regulations – the initiative to draft regulations is always in hands of the Minister specified by law who is delegated the right to issue the specific regulation. There are different practices in each ministry depending on the complexity of the regulation:
 - × a minister may delegate drafting of the given regulation to ministry experts,
 - × a minister may invite a group of experts to develop the fundamentals or less frequently to make a proposal for the regulation itself.

After developing a draft of the regulation, it is reviewed in two stages:

- × by ministry experts who did not participate in the drafting process,
- × by the staff of other ministries and government agencies potentially interested in the field and a number of, so-called social partners (e.g. trade unions, professional chambers, etc.); this is an open-ended list, however, the most important organizations are always present.

After the two rounds of reviews have been completed, and the opinions taken into consideration (accepted or rejected), the regulation is signed by the appropriate minister.

The regulations discussed above which stipulate the various parts of the benefit package were developed in this manner. At this moment in time it is impossible to follow the decision-making process in each case separately.

The only significant difference occurs in case of formulating reimbursement lists of pharmaceuticals. There is a legally established procedure of placement of a pharmaceutical on the reimbursement list. The procedure involves a formal procedure of drug manufacturers

applying for permission to the Minister of Health who assesses compliance with formal conditions and finally the therapeutically and economical features of the drug are assessed a Pharmaceutical Assessment Team. Its members are appointed in very a formalized way. They are representatives of major counterparts in the health care system, including the Ministry of Health, the Ministry of Finance, National Health Funds and professional bodies.

The decision-making process of the National Health Fund was not formalized until recently. Starting from 1998, defining products items, which were subsequently used to purchasing services, was done by NHF staff. Sickness Funds and recently the NHF referred for advice to representatives of the medical profession interested in the specific field (e.g. when defining products in cardiology, cardiologists were asked to cooperate). This approach resulted in a number of controversies and is presently considered as an organized lobbying process, which leads to imbalanced pricing.

In the last version of the social insurance law, the role of providers' official representatives was made official;; this professional organization represents more than 10,000 providers. In particular, a certain role in the process was assigned to the Chambers of Physicians, Nurses and Midwives and other professionals. The organizations contributed to "setting the general rules of tender processes" whose aim is to select providers of certain services.

The decision making process follows governed by ruled which remain unclear. They are usually established internally by the decision bodies and the knowledge of their fundamentals is very limited.

The decision process resulting in drafting reimbursement lists of drugs has provoked the most heated discussion. For many years this area has been characterized by a complete lack of transparency and has been marred by suspicions of heavy lobbyism. The law on pharmaceuticals introduction in 2001 gave more grounds for introducing transparency and a fairer decision-making process in this sensitive area. Recent years, however, continue to give signals that the process is influenced either by manufacturers' lobbies or by the Ministry of Health's political needs.

Discussion

Presented above were legal and administrative regulations of health benefits, to which various groups of inhabitants of Poland have their entitlements. As a reader may observe, the range of available benefits is wide and reasons for entitlements are also various. Interesting is that in common public (also among professionals) opinion there is NOT such a thing like “*benefit package*” defined in Poland. This is a frequently quoted reason, why the system works poorly. There is no systematic research in this area, but one may observe that different parties of the system appeal for “*benefit package*” for different reasons: patients that feel lost in the system, see in the mystic “*benefit package*” a tool for executing their rights (“*Look, there is PET diagnostics on the list, and I want to have it !!!*”). Professionals use to claim, that lack of explicit enlisting benefits make that patients demand more then necessary and physician are placed under a strong pressure to prescribe and perform many services, which are not finally covered by the payer. On the other hand, explicit formulation of “*products*” purchased in the insurance system created a lot of controversies and criticism, since not every potential medical procedure was placed there.

During 1999 and 2000, the Ministry of Health and Social Welfare publicly expressed its commitment to the development of a defined basic benefit package. This proposal was hotly debated for the last year or so, with a number of groups opposing the concept because it was often seen as a way of limiting available health care to save money. The debate prompted the Ministry to seek outside assistance, in the form of the TNO Prevention and Health consulting group. The project launched was aimed at “verifying and arranging the range of services purchased by the Sickness Funds regarding determination of the range of guaranteed services the so-called basic benefit package with specification of terms of their provision. The formulated range and description of services were expected to serve as materials for the Sickness Funds as a basis of signing contracts with services providers, as the evaluation of the execution and for the Health Insurance Supervisory Office and the Ministry of Health as a basis of the evaluation of activities of particular insurance funds (the Sickness Funds).

In February 2004 Constitutional Tribunal of the Republic of Poland announced a verdict that health insurance law was unconstitutional because it failed to define with sufficient precision the *scope of services* that beneficiaries may expect from the national health system, what is mentioned in the Constitution (*Conditions and scope of services will be detailed in the appropriate law – par 62 of the Constitution*). As a result, the Government was forced to prepare a new law, which would fulfil this requirement, within a time of one year, approximately.

In the process of formulation of the new law there were many different possibilities concerned; one that the law would contain a list of medical procedures which are performed in the system. This idea was assessed to be unrealistic very soon, especially because of the short timeframes for preparing the new law. Besides, there were strong voices that preparing *benefit package*, somebody has to make a selection and separation of services which are provided and those which are not, or, more precisely, those benefits which are provided free of charge, partly paid and fully paid by a patient. This concept was defined by a group of experts, formed by Minister Leszek Sikorski and was known under a label of *benefits guaranteed fully and partly*. The concept considered also establishment of a special institution, which would assess effectiveness and cost-effectiveness of medical interventions and participate in decision making process on inclusion and exclusion of the interventions in the *benefit package* for universal health insurance.

In the process of the law formulation, the Agency of Health Technology Assessment, because it was a working name of the institution, was granted different functions and level of power. Initially, in the proposal of the Minister's Experts, the Agency was expected to be an expert institution providing HTA reports, which would be used by the Minister of Health for making decisions. Later in the process, the role of the Agency was developing into decision-making itself, with simultaneous high level of independence. The independence was regarded, at some point of time, as the most important feature of the Agency, namely independence from politicians. However, very soon another opinions appeared expressing concerns that independence from politicians might not mean independence from the industry, what could be even more dangerous. Some critics were saying that independence in inclusion/exclusion decisions of the Agency cannot be supported when Agency has no political neither economical responsibility.

Finally, because there was no common or even prevailing opinion, what would be the final role and position of the Agency, the institution was not established. However, the Minister of Health was obliged, in the last by one paragraph of the insurance law, to "undertake efforts to establish an organizational structure, which task would be to make health technology assessment of medical procedures, with special regard of procedures, which were subject of purchasing by the Fund". A special expert group was formed in February 2005¹⁵, to define a specific range of tasks of the Agency and its organizational fundamentals. According to the present Minister of Health declaration¹⁶, the Agency will be established in the year 2005. However, because the Parliament is finishing its term in summer 2005, no new laws are accepted anymore to the legislation process and no law amendments were presented to define role of it in the system. Other changes in insurance law, namely attachment of a list of procedures, which were NOT included in the benefit package, together with a promise of establishment the Agency, solved the legal controversy between Parliament and the Constitutional Tribunal. In public opinion however, there is still NO SUCH A THING like "benefits package" in Poland.

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¹⁵ ZARZĄDZENIE MINISTRA ZDROWIA z dnia 3 lutego 2005 r. w sprawie powołania Zespołu do spraw przygotowania szczegółowej koncepcji Agencji Oceny Technologii Medycznych

¹⁶ ZESTAWIENIE NAJWAŻNIEJSZYCH ZADAŃ PLANOWANYCH DO REALIZACJI W OKRESIE DO KOŃCA KADENCJI RZĄDU W ZAKRESIE OCHRONY ZDROWIA (<http://www.mz.gov.pl/wwwmz/index?mr=&ms=&ml=pl&mi=29&mx=0&ma=3319>, 27.04.2005).

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Pożądane kierunki zmiany systemu ochrony zdrowia w Polsce. Między racjonowaniem i racjonalizacją, Stanisława Golinowska, Adam Koziarkiewicz, Christoph Sowada, CASE, Warszawa 2004

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