Contracting medical services of intensive therapy by NFZ
in Poland, i.e. life saving services but only partially?

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“He who learns but does not think, is lost! He who thinks but does not learn is in great danger”
Confucius

The Basic Law states explicitly that the State’s role is the best possible expenditure of public financial resources through medical evidence- and modern technology-based health care organisation and quality of health services, which will beneficially affect the society’s healthiness, be cost-effective, hence socially accepted.

The crucial organisational and legal changes in the Polish health care system were initiated by the Act of 1991 on health care institutions [1]. The Act closed the era of state’s monopoly over management and formation of health care institutions. The next key step was the health insurance law of January 1, 1999 enacted by Parliament in 1997 [2]. The law states that health insurance is based on the following separate components:
— social solidarity,
— self-government,
— self-financing,
— right to choose a physician and a health care fund,
— equal access to services,
— introduction of health care funds as representatives of the insured citizens,
— cost-effective and deliberate activities of health care funds.

On April 1, 2003, the Act of January 23, 2003 on universal health insurance in the National Health Fund came into force replacing the law of universal health insurance [3]. The new Act introduced major changes appointing one institution responsible for the insured citizens, i.e. the National Health Fund (NHF). The Act was invalidated on October 1, 2004 by Article 251 of the Act of August 27, 2004 on health care services funded from public resources in response to the Constitutional Tribunal verdict of January 7, 2004 [4]. The Constitutional Tribunal verdict states that Art. 36 and 1 of the Constitution regarding organisation and principles of NHF activities, provision, supervision and control of health care services are unconstitutional (Art. 68 and 2). The public institution that cannot act reliably and efficiently violates the legal principles of the State and the constitutional rights of its citizens to equal access to health care services funded from public resources [4, 5].

Thus, the verdict of the Constitutional Tribunal formed the basis for preparation of the health benefit basket because the Constitution of the Republic of Poland is the basic law that the remaining laws and regulations are based on appropriately to the State and its legal culture. This results from one of the fundamental constitutional regulations, i.e. the right to health care (rightly noticed by the Constitutional Tribunal in its verdict of January 7, 2004; record signature K 14/0.3) [5].

I am fully aware that the above introduction may seem irrelevant from the point of view of organization and funding of anaesthesiology and intensive therapy services as it is remote from everyday struggles with the payer associated with provision of funds and explanations that life-saving services are not the services provided above limit. I do mention this, as in accordance with the verdict of the Constitutional Tribunal, the debates concerning these issues should have been finished at least 8 years ago, yet surprisingly they are being discussed endlessly.

The scientific journal “Anaesthesiology Intensive Therapy” should offer the most valuable papers selected by the Editorial and Scientific Board, thanks to which the Polish Society of Anaesthesiology and Intensive Therapy, the founding body of the quarterly, accomplishes its goals; however, to achieve these goals, some reflections of general nature are required.
The Constitution of the Republic of Poland, Art. 30 recognises inherent and inalienable dignity of man, as a source of freedom and rights [5]. This means that nobody, even the legislator, whose authority comes from the society, can limit human dignity in any way. Article 38 of the Constitution states that legal protection of life is ensured by the Republic of Poland. This ruling obliges the State authorities to find such legal solutions, which guarantee the accomplishment of this goal [5]. According to Article 68, section 1, everyone has the right to health care [5] and the legislator is obliged to define legal norms in such a way as to provide citizens with equal access to health care services funded from public resources, irrespective of their financial status. Moreover, this regulation obliges the legislator and public authorities to determine the principles and range of health service provision. Moreover, the Constitutional Tribunal in its verdict pointed out that access to health care services has to be real and not declarative or curricular. The above solutions resulting from the verdict inspired the government to prepare legal regulations regarding the rights to health care in the form of the health benefit basket.

The life-saving services should undoubtedly be included in this basket and funds for such services cannot be virtual but explicitly real.

The current underestimation of health care services administered by departments of anaesthesiology and intensive therapy (DAITs) exceeds 250 mln PLN, which confirms the legitimacy of the Constitutional Tribunal verdict mentioned earlier, although since 2004 many legal regulations and directives have been formulated, which clearly regulate the responsibilities of the service provider towards the payer and vice versa. I would like to remind you that this responsibility towards citizens, in accordance with the Constitution of the Republic of Poland, has to be real, not declarative [5], and should regard both the service provider and the subject funding health care institutions. No legal regulation can absolve the service provider, the physician in particular, from the obligation to treat patients in life-threatening conditions, which is clearly regulated by the Medical Profession Act. The Act is extremely divergent from the Public Finance Law, which the authorities of health care institutions are faced with [6, 7].

The management of health service provision is to implement the protocols of medical management in selected medical disciplines based on international or national standards to achieve repeatability and effectiveness of therapeutic processes, which will ultimately result in reduced morbidity and mortality rates.

To adopt the quality management systems, e.g. quality management philosophy based on the Six-Sigma strategy, in each case, a subject (according to Six-Sigma, a client) should be defined for whom the selected provider delivers the services in the best possible way [8]. In health care, unquestionably, our client is a patient. In fact, however, according to the system, rightly questioned by the verdict of the Constitutional Tribunal, the payer has become the main client of health care institutions.

The shortage of resources to finance services provided by DAITs postpones the vision of possible funding of anaesthetic procedures. Considering the above, the activities of the Ministry of Health carried out in 2006 and the directive of the Minister of Health to appoint the Expert Group for preparation of central database of health care services (law gazette no.14, point 67), have remained the unutilised collection of information about the structure of medical services and costs related to their provision. The catalogue of the structure of medical services was based on the Current Procedural Terminology (CPT-PL), International Classification of Diseases (ICD-9), Catalogue of NHF Services, International Classification of Diseases and Health Problems (ICD-10), Classification of Medical Devices for Various Purposes, Classification of Drugs, and Classification of Medical Professions and Specialities [9].

In the field of Anaesthesiology and Intensive Therapy, the Expert Group divided the services into 3 main groups:

1. Intensive therapy procedures — 435 (in 23 areas of therapy administered in DAITs),
2. Anaesthetic procedures (block anaesthesias — 80 procedures, general anaesthesia and analgosedation — 80 procedures),

The procedures should be prepared according to the guidelines of the Ministry of Health and include the following elements [9]:

1. name of the service;
2. assignment of the service to the catalogues of medical procedures, CPT-PL in particular;
3. assignment of the service to the NHF catalogue;
4. description of the service including its identification or effectiveness:
   — pharmaceutical agents,
   — medical equipment,
   — auxiliary devices;
5. indications for service provision;
6. description of conditions in which the service should be provided;
7. description of those entitled to deliver the service (key);
8. categorisation of services according to their medical and social health-related significance.

Since the CPT catalogue practically lacks the description of anaesthesiology and intensive therapy services, the Expert Group had to create the structure of services de novo, assuming that they are of positive, beneficial character, thus should be included in the health benefit basket.
The final stage of implementation of the basket was supposed to be its rating performed by the independent Group of Experts from the Agency for Medical Technology Assessment, so that the payer could compare the charges of given services which the available budget for them. Unfortunately, this stage of building the reasonable structure of health service categorization has never been accomplished.

Considering the signals from the NHF chairperson, stressing the necessity to establish the institution to deal with the description and rating of health services, it is worth reminding that such services had already been described in 2007 according to the international guidelines and they should only be priced according to their real values. Importantly, the catalogue was structurally open and new services could be included if experts have recognized that they fulfill the methodological criteria, i.e. “service = procedure + indications” [9].

Given the above, the situation associated with expenditure of public resources for therapeutic anaesthetic and intensive therapy procedures based on preliminary research carried out by A. Piechota and co-workers, which is also indirectly confirmed by the payer, is as follows [10]:

Each year, the regional branches of NHF signing contracts with providers of intensive care services underestimate the amount of money they should assign for funding the services provided by DAITs (in 2009 — by at least 26%, in 2010 — 16% and in 2011 — 15%) [10]. It should be added that these values regard only the contract value for treatment in DAITs and do not define the value of services provided above its value, which are elegantly called by the payer as services over limit. In conclusion, the payer considered some services provided by DAITs as non-limited — albeit limited by the annual contract value, which is extremely risky in the light of the constitutional regulations. Recently, a new therapeutic product has appeared on the health care field of anaesthesiology and intensive therapy [14]. The legal acts define management standards in selected fields of medical specialities, yet do not obligate him/her explicitly to introduce them in the form of a legal act. Thus, it is likely that since January 1, 2013, there will be no legal regulations similar to the Directive of the Minister of Health and Social Welfare of February 27, 1998 on standards of management and medical procedures during administration of anaesthesiology and intensive therapy services in health care institutions [13]. Apparently, proper organization of health care in the field of anaesthesiology and intensive therapy is the key to reduce morbidity and mortality amongst our patients, which is consistent with the Declaration of Helsinki of June 13, 2010, the signatory of which is the Polish Society of Anaesthesiology and Intensive therapy [14]. The legal acts listed above do not have the distinguishing features of documents protecting professional interests of physicians but unequivocally serve the safety of patients in hospital and for this reason were signed by representatives of the International Society of Patients.

Finally, I would like to draw your attention to the fact that in June 26, the Minister of Health signed the directive on detailed requirements to be fulfilled by facilities and devices of the therapeutic institution (subject) [15]. This directive does not include DAIT requirements in Poland, as
such requirements had already been described in the directive project of the Minister of Health of 11.07.2012 regarding standards of medical management in anaesthesiology and intensive therapy in therapeutic institutions and were presented for social consultations on July 11, 2012 [16].

The lack of regulations defining the spatial dimensions of DAIT facilities can induce serious consequences for the safety of patients in these therapeutic subjects, which are organising the intensive therapy stations in DAITs as there is no appropriate legal act. I am deeply convinced that the opinions I shared with you about the structure of health care services delivered in DAITs, the ways they should be proceeded with in future and the Basic Law regulations concerning its beneficiary (i.e. the citizen of the Republic of Poland) will sensitise the circle of Polish anaesthesiologists to the issues in question. In future, this is likely to contribute to practicing the medical profession in agreement with the medical profession law and medical ethics code. I do hope that the aphorisms of Confucius, the first I started with and the other that follows, will make you stop for a moment and reflect on the current situation.

“By three methods we may learn wisdom: first, by reflection, which is noblest; second, by imitation, which is easiest; and third by experience, which is the bitterest”

Confucius

References:
15. Dz.U.12.739 z dnia 29 czerwca 2012 r. Rozporządzenie Ministra Zdrowia z dnia 26 czerwca 2012 r. w sprawie szczegółowych wymagań, jakim powinny odpowiadać pomieszczenia i urządzenia podmiotu wykonującego działalność leczniczą.

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