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IMPORTANCE OF PUBLIC PARTICIPATION IN DECISION-MAKING PROCESS IN HEALTHCARE SYSTEM ILLUSTARTED WITH AN EXAMPLE OF THE DEVELOPMENT OF AMERICAN AND POLISH SCOPE OF HEALTH BENEFIT BASKET

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ABSTRACT

The process of the development of health benefit **basket** may serve as a good example of decision-making process in the healthcare system which is based on public participation.

OBJECTIVE. Comparative analysis of development and implementation of health benefit **basket** in Poland and the USA.

MATERIAL AND METHODS. On a basis of the literature review, following questions were studied, i.e.: What is the origin of health benefit **basket** development in the USA and Poland? What was the role of pubic opinion in determining the range of health benefit **basket** in both countries? What criteria were employed to determine the range of health benefit **basket** in both countries? What conclusions can be drawn for Poland from the USA experience of determining the range of health benefit **basket**?

RESULTS. Irrespective of the similarities in the origin of health benefit **basket** development, both countries approached this issue differently. In the USA, the approach based on social dialogue and patient's perspective was selected while in Poland the perspective of public payer predominated.

CONCLUSIONS. The transparency of principles and social dialogue constitute the fundamental elements of effective process of health benefit **basket** development and implementation which is both required and generally unpopular modification.

Key words*: health care, health benefit basket, public participation*

INTRODUCTION

Public participation may be defined as the process in which the representatives of society have a control over the decisions made by public authorities, provided they have direct or indirect influence on public interests. Due to the public participation, administration achieves the below mentioned benefits (1):

1) transparency of decision-making process;
2) better understanding of public needs;
3) public support for modifications and public authorities activities.

The engagement of citizens and patients in the decision-making process is an entrenched standard in the EU countries. In the light of the Council of Europe recommendations, the development of structures and conditions for social participation appearance and progress is an obligation of national governments as well as its active promotion by the government in all spheres of healthcare at national, regional and local level. (2)

The development of the list of healthcare services reimbursed by the payer (healthcare services basket) in the USA may serve as a good example of decision-making process based on public engagement. It is the process of introducing fundamental modifications in the healthcare system which is accompanied by the atmosphere of great emotions and political and social objections. The introduction of health benefit **basket** in Poland constitutes an example of aforesaid process which was done in a different manner.

MATERIAL AND METHODS

The paper's objective is the comparative analysis of preparation and implementation of health benefit **basket** in two entirely different jurisdictions. It is an attempt to assess the consequences of adoption of two diverse models of social consultation. The example of the USA indicates how the range of reimbursed healthcare services based on social dialogue may be defined. The example of the USA was employed in this comparative analysis due to the fact that American process of health benefit **basket** development is equally actual as the Polish one. Irrespective of the fact that the principles of organization and financing of both healthcare systems are different, the challenges in the healthcare sector settings are similar. One of them being the access to treatment. For instance, the average American and European who suffer from cancer have five-year survival rate amounting to 60% and 40%, respectively (3). However, each success has its own price. In the USA, the level of healthcare expenditures is twice higher than the one observed in the European countries, accounting for 17.6% of GDP while the average for the OECD countries does not exceed 9.5% (3). Simultaneously, almost 50 millions of Americans do not have access to the healthcare services. According to the Commonwealth Fund survey, which was conducted in 2010 on a group of 26 million persons who attempted to purchase health insurance in the period of last 3 years, 6 million persons could not afford purchasing the insurance, 11 million persons were not able to purchase the insurance meeting their needs and 9 million persons have not received the insurance offer or have received the offer of higher price due to the health problems (4).

In the present paper, the following research questions have been established:

1. What is the origin of health benefit **basket** development in the USA and Poland?
2. What was the role of public opinion in determining the range of health benefit **basket** in both countries?
3. What criteria were employed to determine the range of health benefit **basket** in both countries?
4. What conclusions can be drawn for Poland from the USA experience of determining the range of health benefit **basket**?

RESULTS

What is the origin of health benefit basket development in the USA and Poland? One of the fundamental objectives of Obama's reform is to ensure the set of essential healthcare services which are guaranteed in terms of each insurance program. According to the Patient Protection and Affordable Care Act, the healthcare services classified to at least ten categories should be guaranteed, i.e.: ambulatory patient services, emergency services, hospitalization, maternity care, mental health disorder services, prescription drugs, rehabilitative services, laboratory services, chronic disease management and paediatric services (5). Furthermore, the Act specifies that the basis to determine the healthcare services basket should be the range of services offered to an average employee at the place of work (6). It consists in ensuring the access to the broadest range of healthcare services which secures the treatment for patients of diverse health conditions. The law prohibits discrimination due to the age, life expectancy and impairment (6).

In Poland as well as in the USA, the debate on healthcare benefit basket was extorted by the legislative modifications. Irrespective of the fact that the first conception appeared at the beginning of 90s. and the successive one was developing when *Zbigniew Religa* held the position of the Minister of Health, the appropriate process of Polish health benefit basket development was extorted by the judgment of the Constitutional Tribunal of 7th January 2004. The Court adjudicated that the Act of 23rd January 2003 on health insurance in the National Health Fund (Act on the National Health Fund) is inconsistent with the Constitution of the Republic of Poland (7). The Tribunal indicated the necessity to determine the range of healthcare services to which the insured are entitled free of charge, i.e. ordered to stipulate the health benefit basket. According to the Constitutional Tribunal's judges, the challenged Act on the National Health Fund neither have specified the health benefit **basket,** nor have it indicated the criteria to establish the range of services which should be guaranteed to the patients from public resources (8).

Both, in Poland and the USA, the authorities benefit from expert's knowledge to determine the health benefit **basket**. Having searched the optimal approach, the American *Department of Health and Human Services (HHS*) commissioned the independent organization to prepare the expert appraisement. The Institute of Medicine (IOM), which was established in 1970 by the National Academy of Sciences, undertook this assignment. Its objective was to assist the public authorities in decision-making processes regarding the healthcare sector. The expertise aimed at searching the method to define the range of services that should be guaranteed in each healthcare plan (9).

The Polish authorities also benefit from the experts' opinion while determining the health benefit basket's scope. According to the Amendment of the Act on healthcare services financed from public funds, the decisions of the Minister of Health concerning the criteria, which determine whether the particular procedures are to be included in the basket, are based on the recommendations of the President of the Agency for Health Technology Assessment. However, the HTA recom-

mendations are not mandatory and only he can make the final decision whether the particular health technology is to be included in the list of guaranteed services (10).

What was the role of pubic opinion in determining the range of health benefit basket in both countries? The fundamental difference between American and Polish approach consists in the fact that the latter did not engage fully the public opinion while defining the scope of basket.

Ni USA the starting point of the IOM work, which is the independent organization responsible for defining the health benefit basket, consisted in searching the compromise between its breadth and the costs of its execution (11). It was acknowledged that such important decisions on resources allocation in the healthcare sector should be made with the assistance of public.

IOM organized two meetings which were opened for the public. Furthermore, it ensured that the comments and suggestions may be submitted electronically using the Internet platform (12). IOM emphasized the significance of public opinion in defining the health benefit **basket**. It was argued that it is difficult to select one appropriate set of services based only on the substantial prerequisites. The decision-making process consists in searching the balance between the competing options. It was stated that the role of public opinion is indispensable in such situations. It is justified by several prerequisites. Firstly, it demonstrates the social preferences to the authorities. Secondly, it serves as incentive for the public to participate in debates on important issues. And finally, it helps to convince the society that "each voice matters".

The conclusions of IOM were subject to the public debate by the HHS. The sessions for patients, healthcare services providers, insurers and employers were organized (6).

In Poland, the development of the Act on health benefit basket was based on previously issued orders of the President of the NHF which specify the range of medical procedures reimbursed by the public payer. The social consultations were limited to the possibility to submit the written comments to the act draft published on the website of the Ministry of Health between 12th and 20th August 2009. Overall, 45 different institutions submitted their comments to the draft, of which only 3 constituted the patients groups. Taking into account the opinion of some participants of the process with the examples being the Supreme Medical Council or Polish Confederation of Private Employers Lewiatan, the time given to analyze the draft was not enough to address the development of health benefit **basket** accurately (13).

What criteria were employed to determine the range of health benefit basket in both countries? In the USA, on the basis of collected remarks and comments, four basic domains which should be taken into account while developing the guaranteed health benefit **basket** were proposed. These are economics, ethics, evidence-based medicine and public health (12). In Poland, the Act on health benefit **basket** enumerates seven criteria which can be classified to all aforesaid domains, apart from the ethic domain (14).

The economic domain should be mainly referred to the arrangement of conditions for rational allocation of limited healthcare resources. It was defined on the basis of following aspects (12):

1. The insurance should protect against unpredictable excessive treatment costs.
2. The competition is indispensible for enhancement of quality and effectiveness.
3. The public authorities should address the market deficiencies contributing to the situations in which the health insurance which do not meet the needs are offered.
4. The medical procedures enabling to achieve the highest benefit level with reference to the expenditures should be promoted.
5. The risk of moral hazard, referring to the excessive benefiting from healthcare services due to the cost-free access to the healthcare sector, should be minimized.
6. The negative selection, defining as the situation in which the persons having increased risk of developing diseases than persons on average accede the groups of insured more frequently, should be eliminated.

In Poland, the following criteria were differentiated within the economic domain (14):

1. The relation between the costs and health outcomes.
2. The financial consequences for the healthcare system, including the entities liable for financing the healthcare services from the public funds.

While the American approach to define the economic criteria includes the patient perspective, in Poland the perspective of payer predominates. The analysis of the cost-effectiveness of treatment and its impact on the payer's budget rather than preventing the patient from market deficiencies is recommended.

The evidence-based medicine constitutes the successive American domain. The authors refer to the decision-making processes based on current best clinical evidences. The following criteria to determine health benefit **basket** were stipulated (12):

1. Systematic approach to search the best knowledge to make the clinical decisions.
2. Diligence over the usage of evidence-based medical practice in decision-making process.
3. Integration of clinical knowledge, patient's expectations and the best scientific approach in decision-making process on patient's treatment.

In Poland, the subsequent criteria within the evidence-based medicine were distinguished (14):

1. clinical effectiveness and safety,
2. risk-benefit ratio.

As it was stated previously, the comparison between Polish and American criteria indicates that different approaches to their construction were employed. In the USA, the role and expectations of patient are underlined. In Poland, the criteria are mainly referred to the clinical perspective.

The public health domain refers to the role of healthcare system, which consists in ensuring the improvement of population health. The Americans defined the following criteria within this domain (12):

1. Health insurance should aim at achieving the improvement of health.
2. Implementation of prophylactic activities is required at each level of healthcare system functioning.
3. Access for the persons who are in need.
4. Health inequalities should be eliminated.

In Poland, the Act defined the below mentioned criteria within the public health (14):

1. Impact on the improvement of citizens health, with the inclusion of:
   a) health priorities specified in the provisions issued on the basis of paragraph 2,
   b) incidence, prevalence and fatality rates estimated on the basis of current medical knowledge;
2. Disease consequences such as:
   a) premature death,
   b) inability of unaided existence as defined in the provisions on pensions and disability pensions paid from the Social Insurance Fund,
   c) inability to work as defined in the provisions on pensions and disability pensions paid from the Social Insurance Fund,
   d) chronic suffering or chronic disease,
   e) negative impact on the life quality;
3. Significance for citizens health, with the inclusion of the necessity to:
   a) rescue the life and achieve the recovery,
   b) rescue the life and achieve the improvement of health status,
   c) prevent from premature death,
   d) improve the quality of life without significant impact on its expectancy;

From the comparison of the criteria within the public health domain transpires that there are no significant differences between the analyzed countries. However, the absence of need of health inequalities elimination in the Polish criteria should be emphasized, which was specified in the American version.

Apart from the aforesaid criteria, the domain including the ethic aspects was elaborated in the USA:

1. Transparency regarding the mechanisms of resources allocation.
2. Participation defined as listening to the public opinions.
3. Equality indicating the necessity to prevent from discriminating the individuals.
4. Promotion of the healthy behaviors.
5. Solidarity guaranteeing the access to the healthcare services for the persons in need.

The distinction of ethic domain aimed at granting the equitable resources allocation and reliable management of financial resources available in the healthcare system to ensure that the rights of all patient groups are treated with due respect. In Poland, the ethic aspect was omitted.

In the USA, the process was not constrained to the criteria employed while developing the health benefit **basket**. The collected public comments and suggestions were also used to determine the criteria of prioritization, including (12):

1. Transparency which indicates that the process of healthcare services selection should be subject to public opinion assessment.
2. Participation which demonstrates that the insured have the right to decide on the basket scope they are entitled to.
3. Equity and justice which ensure that none of the less privileged social groups will be left without due care while developing the healthcare services basket.
4. Effectiveness which convinces that the selected services ensure the improvement of population health and were based on medical evidences.
5. Flexibility which grants the amendment of the basket provided there is information on effective therapies.
6. Innovation which ensures the access to the new treatment methods.

What conclusions can be drawn for Poland from the USA experience of determining the range of health benefit basket? Initially, the positive basket, as well as the negative one, appeared to be the revolution in the sense of legal organization of healthcare system in Poland. Having considered its practical sense, it did not contribute to the significant modifications and still constitutes the excessive set in comparison to the NHF financing capabilities.

The American approach has also been subject to similar criticism. Irrespective of the fact the conception of set of essential healthcare benefits is one of the leading ideas of the President Barack Obama, it has both opponents and supporters in the group of politicians, media and public. The dissatisfied persons claim that the propositions are not revolutionary enough. In the protest letter, which was undersigned by 2,400 physicians and nurses, the HHS was accused of the low quality of the developed list of guaranteed set of essential healthcare benefits (15). Similarly, in Poland the critics also claimed that the proposed modifications make the system more

social and contribute to the bureaucratic centralization of healthcare system organization. Thus, it infringes the individual's freedom by defining the range of available healthcare services and introducing the obligation to purchase a private healthcare insurance.

To meet these objections, the President *Barack Obama* demonstrated the understanding for the criticism of the process centralization. He declared that he did not support the conception of one standard set of essential healthcare benefits. He acknowledged that the development of the range health benefit basket financed within the health insurance should be the obligation of local authorities. In December 2011, HHS announced that each state should determine its own set of healthcare services basket. Given the health insurance, which does not include all 10 categories defined in the Act, was selected, the public authorities are to supplement the lacking positions on the basis of offer from another insurance. Additionally, each state may determine broader list of services than the one defined as the basic. According to the law, the local authorities are obliged to cover additional costs resulting from the increase of insurance standard.

In Poland, the excessive centralization of decision-making process is also discussed. According to the Article 31b of the Act, the Minister of Health is responsible for defining the healthcare service covered by the public funds, after obtaining the recommendation of the President of Agency for Health Technology Assessment (AHTA) (14). Contrary to the USA, the decentralization or regionalization of process although are not discussed.

In Poland, the role of out of pocket payments is also highlighted. It is criticized that the Polish legislator enables patient's co-payment, but so far has not initiated the debate on this subject. The term 'health benefit **basket'** was defined as the healthcare service which is entirely or party financed from the public resources on the terms and to the extent specified in the Act (12). However, it still has not been decided whether any forms of cost sharing for the non-drug procedures or voluntary healthcare insurance should be introduced. The level of out of pocket payments was determined only in the case of official drugs, medical devices as well as the additional co-payments to the sanatorium services. The remaining elements of basket, such as non-drug services, are to be resolved by the Agency of Tarification which has not been appointed yet. It was introduced irrespective of the numerous social surveys which indicated the acceptance for co-payment and private healthcare insurances and despite of the social consultations held during the White Summit (16).

During the debate in the USA, the patient direct participation in the healthcare financing was also covered. They warned against the possible increase of insurances premiums as the consequence of guarantee introduction to reimburse treatment of particular set of health conditions. It is indicated that the multitude of bureaucratic tasks that the insurers and the local authorities have to face may contribute to the significant increase of level of patients co-payments or deterioration of social status of many citizens (14). In the USA, the conservative media concentrate on the significant element of Act, i.e. obligation to purchase the insurance under the pain of imposition of penalty in the form of tax. The new personal income tax amounting to 2.5% is to come into effect in 2016. Thus, the average family who has not purchased the insurance is to pay 2,055 dollars of penalty/tax. The decision was challenged to the Supreme Court as being inconsistent with the Constitution. In June 2012, the Supreme Court of the USA adjudicated that the federal government has the right to impose the penalty due to failure to purchase the obligatory insurance. Having considered the role of public opinion in the light of concerns for excessive patients' financial burden, the public debate was initiated. Contrary to Poland, the focus groups and the meetings opened for the representatives of local societies were organized as well as employing the contact via Internet. The objective was to achieve the social consensus regarding the patient's financial engagement in the healthcare system financing and organization.

SUMMARY AND CONCLUSIONS

In the USA, the approach adopted aimed at ensuring the balance between the scope of basic healthcare services and the financial constraints. In Poland, together with mechanic transferring of the list of healthcare services from the NHF categories to the health benefit **basket** regulations, the attempts to adjust its scope with the payer's budget capabilities were not undertaken.

In both jurisdictions, the scope of reimbursed healthcare services is similar. In Poland as well as in USA, the inclusion rules are based on clinical effectiveness and cost-effectiveness. While considering the similarities between the health benefit **basket** in these two systems, the approach maximizing the improvement of population health status should also be mentioned.

The main difference, which influences the processes of health benefit **basket** implementation is based on different perspectives adopted in both countries during the process of its creation. In the USA, given that the process of set of essential healthcare services development at the very beginning included the social consultations, the perspective of insured and patient has been ensured. In Poland, the process of health benefit **basket** development, accompanied by limited public participation, was continued mainly from the payer's perspective. The analysis of both processes inclines to establish the following hypothesis, i.e. while in Poland, the fundamental

objective was the attempt to reduce the public expenses, the intention of American authorities was to protect the patients against excessive healthcare expenditures.

The implementation of health benefit **basket** is one of the greatest systemic revolution in each healthcare system. Taking into account the principles of the American system, i.e. large number of competing private insurers, free market regulating the healthcare services, numerous group of uninsured persons and very high costs of services, it is the revolution of special and historic nature. Irrespective of the concerns, this reform has not finished *Barack Obama's* first presidency. Furthermore, it guarantees him honorable place among the presidents, i.e. reformers such as *Abraham Lincoln* or *Franklin Roosevelt*. Irrespective of the escalation of social tension about the *Obamacare* Act and negative opinions expressed by public, media and political opponents, *Barack Obama's* administration afforded undertaking the transparent, objective and considered process of social consultation regarding very important but also unpopular systemic modification from the social perspective.

Thanks to the public consultations, the American process of health benefit basket development was based on several important values, i.e. transparency of resources allocation mechanisms, equality, solidarity, promotion of behaviors maximizing the health benefits. The social consultations introduced also something which was lacking in the Polish process, i.e. determining the flexibility and innovation as its characteristics as well as constant revision and actualization of the basket were determined as its basic features.

From the American experience transpires that public engagement in the decision-making process requires transparency. The representatives of local societies, who participate actively in the process of healthcare services basket development, should be precisely informed how the process proceeds, what their role would be and how their contribution is to be used. Unless stakeholders' engagement is employed on the transparent principles, the endorsement for all necessary limitations to access to treatment by the public opinion will not be achieved. The health benefit basket in the USA has not been entirely defined yet. Unlike the Polish basket, it has not withstood the test of time and has not the chance to be verified in practice. However, it can be speculated that the process of social consultations accompanying its development will support the basket implementation and its acceptance at the time of introducing the modification. The American basket may serve as a tool ensuring the balance between the private and public healthcare expenditures. Irrespective of the long-term process of basket development and improvement, the Polish basket is still of theoretical nature and does not meet the function of systemic regulator. Thus, it is high time to subject it to social consultations and benefit from its potential.

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