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RISK MANAGEMENT AND RISK TRANSFER IN HEALTH INSURANCE

1. The nature of risk

Risk is essential for socio-economic activities and for those actively involved in them. There are many definitions of risk in use in the literature. So far, however, a clear definition, which depends obviously on the specificity of circumstances and aspect of research interest of the investigator, has not been established. For every scientific field, insurance risk is understood in a different way. Importantly, risk is an object of interest to many scientific disciplines, including, among others, economics, law, insurance, accounting, mathematics, probability and statistics. Therefore, it is crucial to find a meaningful definition of insurance risk. At this point, risk should be approached in two ways. On one hand, this approach is characteristic for the economic thought, on the other, the insurance law will be a driving force defining the concept of risk.

Risk in the economic though approach is recognized by specific dangers - hazards, which are perceived as a cause of real incidents, facts, or certain socio-economic events. Attention in this approach is focused on the perspective of proper dangers. In the second approach, risk is seen as states of the external world (events) that are a result or the various risks occurrence. This approach is characteristic to the insurance law science, and, unlike the first approach, recognizes the risk from the side of effect, and not from its cause¹. Hesitating to take a deeper analysis of the definition of risk at this stage, this paper presents various and most commonly used definitions of risk²:

Risk is a danger - this is an incorrect identification of risk in an everyday use as a synonym of danger. Danger is actually a cause or source of risk. This definition is an example of a methodological confusion, and following, it demonstrates a lack of understanding of the nature and complexity of risk.

Risk is uncertainty - the risk should also not be equated with uncertainty. Uncertainty is only a correlate of risk (the presence of risk is only a source of uncertainty). The risk is an objective category, while the uncertainty is a subjective category, since it determines our understanding of the laws governing the objective process.

Risk is the chance of the occurrence of loss - it is a possibility or probability of a specified outcome in the event of a loss. Although, it needs to be emphasized that the degree (amount) of risk level and the probability of a given consequence (loss) are not identical.

¹ Podstawy ubezpieczeń, ed. J. Monkiewicz. Wyd. Poltext, Warszawa, vol. I 2005, pp. 17-19.

² Podstawy..., op. cit., vol. I 2005, pp. 28-31. Ronka-Chmielowiec W., Ryzyko w ubezpieczeniach – metody oceny. Wyd. AE im. O. Langego we Wrocławiu, Wrocław 1997, pp. 18-23. Rutkowska M., Ubezpieczenia zdrowotne. Agencja Promocyjna Monada s. c., Wrocław 1997, pp. 12-19.

An opportunity of loss is the possibility or probability that something will happen. This does not mean the same as the degree of probability.

Risk is the possibility of the occurrence of loss - is the probability of a certain result, described between the between the probability of zero and one. The risk in this case is an unknown. Important is whether the possibility of occurrence of the insured event existed or not in a moment of the contraction. This definition is the closest to the common meaning of risk, but not sufficiently concrete and not suitable for quantification of the magnitude of risk.

Risk is a condition in which a possibility of loss exists - in this approach the risk is a certain state of reality, in which there is the possibility of an adverse deviation of the actual result from the assumed or expected one in a given situation. Risk measurement refers in this case into both, the individual as well as to the collective risk. Risk is measurable using the probability of loss incidence. The measure of risk is the possibility of other deviations from the expected results.

Risk is the dispersion of actual and expected results – a degree of dispersion of results in relation to the central or average position is evaluated in this understanding. Such an approach is mainly found in statistics.

Risk is the probability of a different result than expected - the risk is regarded as the probability of deviation of the actual result from the expected in the so-called collective risks scale, and not as a probability of a single event occurrence.

Risk is a subject of insurance - the risk is identified with the subject of insurance. This understanding of risk is characteristic of the technical language used in daily practice of insurance. However, whilst useful in the sense of communication, it is of a little cognitive value. Thus, it will be treated here as jargon definition.

The variety of definitions indicates that the insurance risk is thus put next to concepts such as danger, uncertainty, possibility, probability, or threat.

2. Risk in the health insurance

Health insurance has been designed to protect a man and human activities against the effects of adverse events that are a consequence of the existence of risk occurrence in the nature. Health insurance, according to the general and widespread understanding of this concept, is insurance from the loss of health. This insurance guarantees a compensation of financial losses occurred, arisen from the emergence of the income loss risk and the increases in expenditures risk. The risk of income loss is associated with temporary or permanent incapacity to work resulting from the disease. The risk of increased expenditures is mainly related to all expenditure allocated to health treatments necessary to the insured³.

By risk in health insurance we should understand a random event, a situation, where at least one of the elements of which this situation is composed it not known, but what is known is the probability of its occurrence. Whether or not the benefits agreed in the contract will be provided depends on the future. The agreement will therefore achieve its effect only when both parties are ready to bear the consequent risk. The systematization of the risks follows the successive phases:

Decision phase – a decision as to the provision of insurance, depending on gender, age, residence, health status and other variables considered relevant is taken here. The insurance

³ Podstawy..., op. cit., vol. I 2005, pp. 426-430.

is given on the basis of information obtained. The risk supported here is the information risk. The possibility to boarder this type of risk is made by examining the reliability of the information (e.g., additional medical examinations).

Contract phase - both parties sign the insurance contract. In this situation, the risk supported covers the possibility of deteriorating the economic situation of insurance company, which may lead into the bankruptcy declaration. On the other hand, health and economic situation of the insured may also worsen, in a way that a fixed premium will not be paid to the insurer. A threat is defined as the risk of bankruptcy.

Liquidation phase - a claim of the insured (or of the insurer) will be met partially or will not be met at all. This risk is here referred to the risk of loss⁴.

Elements (factors) of the risks that affect its size and intensity are:

- Danger – being a cause or source of losses. A characteristic feature of danger is determined by the sequence of time. There are three, arranged in time phases:• Phase I – the danger - there are situations that give origin to a given danger• Phase II – the act - the implementation (realization) of this danger occurrence• Phase III – effects (consequences) of the danger.

For example, in the case of disease, there is always some risk of infection, the risk of disease incident, the act of realization identified with the proper disease and the effects are assessed by the size of specific losses as a result of the disease.

- Hazard - the set of conditions and circumstances in which the certain risk is realized. Hazard is differentiated into:
 - Physical hazard - a group of external conditions or physical characteristics, which have a direct impact on the chance to realize the risk, in particular, having an impact on the increase of the objective probability of occurrence the accident in cause.
 - Moral hazard – the conditions and subjective attributes of the insured expressed in the negative tendencies of character or personality
 - Motivational (spiritual) hazard - a subjective reaction of the insured caused by awareness of the existence of the insurance coverage. It consists of the reduction of care, on negligence or indifference to certain risks (threats)⁵.

In the discussion on the risk, the stress must also be put on a split between the subjective and objective risk. By subjective risk we understand an individual assessment of a chance to occur a particular outcome. Objective risk is defined as a possible margin of an error of the relative deviation of actual loss in relation to the expected values⁶.

For the assessment (evaluation) of insurance risk it is important to conceptualize underwriting. The term, derived from English, means signing. These are the guarantees⁷ that are given by a representative of the insurance company. In other words, underwriting is a

⁴ M. Rutkowska, *Ubezpieczenia zdrowotne*. Agencja Promocyjna Monada s. c., Wrocław 1997, pp. 13.

⁵ *Podstawy...*, op. cit., vol. I 2005, pp. 1919-1924. T. Sangowski, *Ubezpieczenia gospodarcze*. Poltext, Warszawa 1998, pp. 23-25.

⁶ T. Sangowski, *Ubezpieczenia...*, op. cit., pp. 1927-1928.

⁷ the person signing the contract guarantees the reliability of the information included into the contract and the validity of the policy issued.

group of activities carried out in order to assess the appropriate conditions to accept or reject the insurance risk⁸. The following tasks of underwriting can be distinguished:

- risk assessment from the medical, financial, professional and moral, and assigning the beneficiary to the relevant risk class,
- creating own morbidity and mortality statistics,
- creating a diversified commercial insurance offer in order to increase the competitiveness of the insurance company on the market,
- setting the own underwriting rules and adapting them to the needs of potential customers as well as to the current trends,
- the protection of the insurance company from taking too large and uncertain risks.

The consequence of the risk assessment is a differentiation of the premiums, depending on the dimension of the risk of morbidity and risk of mortality. In practice, this would mean lower premiums for those with less risk (genetic predisposition, work in arduous conditions, etc.). In the process of risk assessment, thereby calculating the insurance premium and setting up the conditions of coverage, it is important to assign risk to the appropriate category. Therefore, the risks are divided into classes. The following types of risks can be found in the literature:

- Standard risk – by which the average incidence of a disease is estimated. With this risk, the insureds pay an average standard fee.
- Preferred risk – where the intended beneficiaries are predicted to present less morbidity on the basis of the unladen family history, very good health condition, no drugs use. In this case, the fee is lower than the standard premium.
- Increased risk - the risk at which there is a greater incidence of a disease. This risk is assessed on the basis of the family history, medical examinations or medical tests. The fee paid is higher than the standard premium.
- Delayed risk. This form of risk occurs when such is very high and then we speak about a so-called “grace period” or postponement of such liability of the company for a few years. It is used often in cases of serious disease such as cancer, in case of persons with HIV / AIDS, plastic surgeries or mental illness.

Knowing the specific classes (categories) of risk the underwriter⁹ decides, basing on the elaborated medical and non-medical data, as to the terms of insurance and the premium. Indeed, the premium depends on the estimated level of risk and the age of the beneficiary. The higher the risk and the later insured the beneficiary (health insurance shall be understood here as an additional and voluntary contribution), the higher the premium, which the insured will have to pay to the insurance company.

3. Risk factors in health insurance

Risk is present in at least two different aspects, namely in its objective and subjective aspect. Moreover, among the factors to be taken into account when assessing the risk in health insurance, medical and non-medical factors are also taken in consideration¹⁰.

⁸ O. Doan, *Ubezpieczenia życiowe. Poltext*, Warszawa 1996, pp. 115.

⁹ a person who verifies and analyzes insurance policies and participates in the evaluation of claims.

¹⁰ *Podstawy..., op. cit.*, vol. I 2005, pp. 27. O. Doan, *Ubezpieczenia życiowe. Poltext*, Warszawa 1996, pp. 122-130.

Objective and subjective factors influence the risk in health. These factors somehow overlap, in some ways, with the medical and non-medical factors.

Physical and documented characteristics of the insured, such as health status, age, gender, occupation and environment (surrounding conditions) are elements included into objective factors:

- In the first years of life it is a prone to disease - the incidence of disease is relatively high, and then it proceeds (up to 40 years of age) on a certain stable level. In later years, it becomes every time more frequent.
- Also, *a gender* affects the degree of risk. The risk course is different for men than for women. The incidence of disease for women is much higher than for men, even when delivery is not taken into account. The first point of the greatest risk among women is reached around the thirty years of age, then it decreases significantly - up to fifty years of age and increases again - here, however, less than in men. The dependence of morbidity on age and gender is statistically proven. It is important to use both of the above characteristics when creating the rates for the respective risk groups.
- Further objective factors include *the employment and the environment*. It is scientifically shown that the rural population suffers from various diseases less than residents of large cities. Also, climatic relations and other regional differences affect the living conditions. Certain occupations have a higher incidence of disease than others. Some are related to occupational diseases (pneumoconiosis, allergies, leukemia).

In case of objective characteristics of risk, charges are included in the respective claims. For the subjective risk characteristics, an accurate and detailed examination is necessary. It is of particular importance for the health insurance, since once accepted and fixed charge cannot be supplemented or amended.

Into the subjective factors those associated with lifestyle, culture and the environment are considered.

- A subjective characteristic for the risk is the insured's health condition. The probability of disease occurrence in the future depends on many factors, so called risk factors and is higher in patients already ill and with low resistance than in health ones. Interesting for the insurance contract are diseases from the past. Moreover, the constitution of the body (structure) – growth and weight - as well as biological factors - high blood pressure, pulse, reflex – say a lot about the health of the individual.
- Certain life habits (e.g., smoking and excessive drinking, lack of exercise) adversely affect health.
- Also professional activity may have a subjective importance, since it may be related with a threat of infection, lack of movement and an increased stress and nervousness.
- The negative impact on the psyche may also be exercised by difficult family relationships, and so, it is important that personal and financial issues, the professional relations are in order and general confidence is established.

As the possibilities of insurance fraud is relatively numerous in the case of health insurance, these are objective rather than subjective factors that are of greater importance,

differently than it happens in other insurance areas. Objective factors are called physical risk, while subjective factors – moral risk.

The second group of risk is that of non-medical and medical factors. Among medical factors, age, family history, medical history and/or medical examination, sometimes even sex, are considered.

- *Age*
- With age, the likelihood of developing certain diseases and likelihood of death increase. Thank to medical advances and better social conditions, there has been a shift in length of human life. However, the life expectancy of individuals is unquestionably further influenced by economic, social and environmental aspects and factors characteristic to each insured which may until any extent impact the lifespan need to be included in the insurer's operational procedures.
- *Genetic*
- The probability of disease incidence is also genetically conditioned. Therefore, while estimating the risk the family history becomes pertinent. The occurrence of the given disease¹¹ (genetic conditioning of its occurrence) among the closest family members increases the risk.
- *Medical interview and/or medical examination*
- Medical history relates to general questions about the health of the insured. Among them there are:
 - Weight and height.
 - Obesity is a serious factor increasing the risk of disease occurrence (a more frequent cases of cardiovascular disease, diabetes, hypertension), which is why overweight people pay higher premiums.
 - Blood pressure.
 - Particularly important at this point is hypertension, which is a cause and risk factor to a heart attack, a stroke and kidney complications. The medical practice is used to the division of hypertension, according to the American experts¹² into the three degrees of risk:
 - First level - systolic blood pressure: 140-159 mm Hg, diastolic blood pressure: 90-99 mm Hg
 - Second level - systolic blood pressure: 160-179 mm Hg, diastolic blood pressure: 100-109 mm Hg
 - Third level - systolic blood pressure: > 180 mm Hg, diastolic blood pressure: > 110 mm Hg.
 - Individual organ disorders.
 - Cardiovascular diseases and cancers are included into this group. These diseases have been considered civilization diseases. They represent the greatest threat to human health and life, because a constant upward trend in the morbidity has been maintained for many years. The questions included in the insurance proposal concern the past and the present health status, treatment history, surgeries undertaken.
 - Stimulants.

¹¹ for instance, such as cardiovascular disease, hypertension, diabetes, cancer, mental illness.

¹² *The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and treatment of High Blood Pressure, NIH Publication no. 98-4080, 1997.*

Tobacco - at the insurance contract preparation phase, a special attention is given to the fact if the insured smokes and if so, in what quantities. Negative effects of smoking are cumulative with age and number of cigarettes smoked per day. In smokers the risk of lung diseases, such as cancer, emphysema, myocardial infarction, is higher. It is also important to verify the quantity of a daily, weekly or monthly consumed alcohol and an eventual drug use. Both these stimulants, alcohol and drugs, increase the risk of morbidity:

Alcohol – inflammation of the pancreas, ulcers, diseases of the esophagus, cancer of the mouth, pharynx, larynx, esophagus, stomach, liver and degenerative changes within the central and peripheral nervous system,

Drugs - diseases affecting the entire human organism.

With the possibility of significant risk the insurer may refer a beneficiary for a medical examination.

- Gender

The incidence increases progressively with age, being greater in women. Hence, the premiums of women may be set up at higher level.

In addition to these medical factors, the risk in health insurance is also affected by non-medical factors. These include:

- occupation – the estimated risk of occupational diseases also affects the amount of insurance premiums to be charged. Among the occupational threats those related to the environment are frequently referred (work inconsistent with the safety rules, illegal employment), but also physical threats (high-voltage work, contact with corrosive carcinogens, and radioactive substances), and the danger of an accident (diving, new vehicles testing),
- sports, hobbies, leisure activities – professional sport increases the amount of the premium paid.

4. Risk management process and risk transfer in health insurance

The question of risk in health insurance is a subject of study mainly on the specific conditions of the external world, i.e., random events, which are the result of the materialization of certain risks. A random episode occurs independently of the will of a person it influences. The disease in this case is a random event, which is the result of natural forces, and human factors, in practice existing as accidents.

A process of managing the risk in the insurance terminology encompasses systematic identification, both qualitative and quantitative, and treatment of risk, process of risk reduction and processes and structures that are directed into using opportunities while managing adverse events. These multiple elements go through the risk selection into the best method of risk control together with its implementation and the effectiveness assessment¹³. Risk management provides a clear and structured approach to identifying risks. Within an organization, risk management should be a continuous process integrating the organizational culture with operational levels of its functioning, thus running from the strategy into its implementation. It has to translate the strategy into tactical and operational objectives. Risk management ensures that the risks to which an entity/person is being exposed are identified.

The purpose of risk management is to make decisions regarding the protection of a defined target that has some value. This real target designated a “protected unit” can exist

¹³ T. Sangowski, *Ubezpieczenia..., op. cit., pp. 44.*

under several, relatively different forms, depending on what a given culture, society or individual considers valuable. In case of human health, a proper person (and health in general) or a human organ can also be understood as a protected unit. The essence of risk management are certain procedures that accompany decision making under risk and so, risk management objective will be to identify, analyze, and to eliminate or reduce as much as possible the exposures to loss faced by a person.

The term “risk management” is relatively recent and has had a twenty-year-long evolution from the concept of insurance management. Starting with mandated work-injury, health and old-age social insurance in some developed countries in the end of the 19th century, some 100 years later, most industrialized countries have public provisions to deal with the “social risks” (such as work injury, sickness, disability, death and unemployment) for a major share of their populations [Holzman and Jorgensen 2001, pp. 534]. The concept of risk management encompasses a much broader scope of activities and responsibilities than insurance management.

According to Williams and Heins¹⁴ the risk management process classically includes six steps: determining the objectives, identifying exposures to loss, measuring these exposures, selecting alternatives, implementing a solution, and monitoring the results.

- The risk assessment is undertaken within the context of goals. The critical step is, hence, a comprehension of what these goals are.
- Risks that are the most likely to occur, given specific characteristics and circumstances, together with their sources and potential impacts need to be rigorously identified.
- Based on this assessment, the risks in terms of likelihood and consequences are analyzed.
- Risk treatment is determined with strategies of the option selection. This is developed and implemented according to the treatment strategy.
- Results are monitored and effectiveness of risk treatment is reported at regular intervals.

In response to identified risks, individuals and groups have historically employed a number of techniques for reducing or mitigating adverse health effects. These include the following¹⁵:

- avoiding or eliminating the risk, such as prohibiting the use of a potentially dangerous object or substance
- regulating or modifying the activity to reduce the magnitude and/or frequency of adverse health effects, e.g., by constructing dams, levees, and seawalls
- reducing the vulnerability of exposed persons and property, e.g., by requiring the use of safety devices, by immunizing the population
- developing and implementing post-event mitigation and recovery procedures, e.g., by establishing search and rescue teams, providing first aid training

¹⁴ C.A.Jr Williams, R.M. Heins. *Risk Management and Insurance*. McGraw-Hill, 1989

¹⁵ V.T. Covello, J. Mumpower. *Risk analysis and risk management: a historical perspective*. *Risk Analysis*, volume 5, issue 2, 1985, pp. 39.

- instituting loss-reimbursement and loss-distribution schemes through such mechanisms as insurance systems or incentive pay schedules for high risk activities

Although all of these techniques are still practiced, most of our current ideas about societal risk management are rooted in four basic strategies or mechanisms of control: insurance, common law, government intervention and private sector self-regulation.

The purpose of risk management is to find the least costly financing method for negative economic consequences of individual risks in specific circumstances. The decisions taken and solutions chosen need to be kept under a constant review in terms of their efficiency and expediency. The practice of risk management utilizes many tools and techniques, including insurance which is a common instrument of the risk control. Insurance covers the risk providing a beneficiary a cover for losses caused by realization of this risk. Insurance, however, is not the only method of risk management, which mainly is due to the high cost. Therefore, in certain insurance conditions, more optimal methods of control and risk financing are in use. Among the methods of risk management (manipulation)¹⁶ the distinction falls into¹⁷:

- Risk avoidance. It belongs to so-called negative methods of risk manipulation and consists of eliminating the risk by a conscious giving up of the action, such as not entering into a marriage. Avoidance may seem the answer to all risks, but avoiding risks also means losing out on the potential gain that accepting (retaining) the risk may have allowed. We shall stress out, however, that the total avoidance of the risks it is impossible to achieve.
- Risk retention. It involves accepting the loss, or benefit of gain, from a risk when it occurs. This method is one of the most common and the best way of handling the risk. Its use may derive either from a conscious decision or from ignorance. Risk retention may be a feasible strategy for small risks where the cost of insuring against the risk would be greater over time than the total losses sustained. Risks that are not taken into consideration through avoidance or transfer are retained by default. Risks which dimension or consequences could be dramatic and what would require an extremely high premium setting will probably be supported and also enter in this group. Risk retention may be proactive or reactive. *Active risk retention* occurs when a person/organization who decides to stop a part of a total of risk is aware of the existing risks and their potential effects. The decision is taken due to financial (e.g. to save on the insurance premium) or non-financial reasons (e.g. unavailability of insurance or some other method of risk transfer), or when the decision to stop the risk is caused by excessive insurance premiums. *Passive risk retention* is a result of involuntary risk maintaining because of laziness, arrogance, ignorance or indifference. Assuming risks simply means accepting the possibility that a loss may occur and being prepared to pay the consequences.

The use of both of these methods may, though, lead to serious financial difficulties and even to the financial ruin threat of a person or organization. The most practical and common method of risk handling is insurance, which boils down to the risk transfer,

¹⁶ methods of handling the risk. The most appropriate here is the term "manipulation". This is not about its common meaning, but the technical, emphasizing the variety of possible ways of behavior toward the insurance risk and the flexibility of these methods [6, pp. 46].

¹⁷ T. Sangowski, *Ubezpieczenia...*, op. cit., pp. 46-50.

distribution and control. It is then a method that relies on a combination of the methods discussed above which allows an individual/organization to pay a regular rather small premium in exchange for protection against a variety of risks. Because of its costs, the insurance option is usually chosen when the other options for managing risk do not provide sufficient protection. Awareness of and familiarity with various types of insurance policies is a necessary part of the risk management process. Insurance as an instrument belongs to another risk treatment group called "risk sharing", briefly defined as sharing with another party the burden of loss from the risk, and the measures to reduce the risk. In the terminology, the purchase of an insurance contract is often described as a "transfer of risk". Transferring risk refers to the practice of placing responsibility for a loss on another party by means of a contract. A purchase of insurance by itself, however, is not risk management. Risk management is a commitment to prevent damage. The term "risk transfer" is often used in place of risk sharing in belief that a risk transfer to a third party through insurance happens under any circumstances, what in practice not necessarily can occur to be true. Legally, the responsibility of losses stays in the insurance policy holder's hands, and insurance is here understood as a post-event compensation mechanism. Insurance is a valuable risk-financing tool. Few organizations have funds or reserves necessary to take on the risk themselves and pay the total costs following a loss. Cutler and Zeckhauser¹⁸ remind an "adverse selection" phenomenon, which has been an important concern in health insurance, especially while most of systems face an urgency of health and social services organization reform and the employment health insurance is being questioned and discussed (see also Enthoven¹⁹ for further discussion). Individuals who expect high health care costs differentially prefer more generous and expensive insurance plans; those who expect low costs choose more moderate plans. Individual choice among health insurance policies may result in risk-based sorting across plans. Adverse selection can lead to three classes of inefficiencies: efficiency losses from individuals' being allocated to the wrong plans; risk-sharing losses, because premium variability is increased; and losses from insurers' distorting their policies to improve their mix of insureds. In this way, prices to participants do not reflect marginal costs, hence on a benefit-cost basis, individuals select the wrong health plans; desirable risk spreading is lost; and health plans manipulate their offerings to deter the sick and attract the healthy. Insurance policies need to balance between the risk sharing and the incentive to seek for more help when having the insurance than when not. Also, proper physicians tend to provide more medical care services when the reimbursement level is properly high. Both, moral hazard and demand incentives have been proven to play an important role in a search for the optimal health insurance policy and insurance arrangements.

Literature points out one more group of risk management behaviors, which is risk reduction. Risk reduction or "optimization" involves reducing the severity of the loss or the likelihood of the loss from occurring.

Some ways of managing risk fall into multiple categories. Risk management may then be proactive or reactive, from a perspective of an individual/entity in cause. The proactive risk management means avoiding or preventing risk. The reactive focuses on minimizing the loss or damage after an adverse incident.

¹⁸ Cutler D.M., Zeckhauser R.J., *Adverse Selection in Health Insurance*, in: *Frontiers in Health Policy Research*, volume 1, ed. A.M. Garber. MIT, 1998. 1-2.

¹⁹ Enthoven A.C. *Employment-Based Health Insurance Is Failing: Now What? Health Affairs*, 2003.

In the implementation phase of the risk management process, any elective combination of these risk management tools may be applied. In an enterprise environment, a monitoring phase will engage a regular review of the company's risk management tools to determine if they have obtained the desired result or if a necessary modification and adjustment are required.

5. Literature

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Summary

Risk is an intrinsic component of human life and thus, of any economic activity. Different sciences characterize and comprehend risk in a different way, depending on a given field specificity, impeding consequently its uniformity. This results in a variety of definitions of risk.

Health insurance has been designed to protect people and their activities against the effects of undesirable events that are a consequence of the existence of risk occurrence in the nature. The question of risk in health insurance is a subject of study mainly on the specific conditions of the external world. Risk management provides a clear and structured approach to identifying risks. The purpose of risk management is to find the least costly financing method for negative economic consequences of individual risks in specific circumstances. The consequence of the risk assessment is a differentiation of the premiums, depending on the dimension of the morbidity and mortality risks.

In this paper, we discuss risk management and risk transfer in health insurance. The concept of risk is presented, followed by its understanding characteristic for the economic thought and the insurance law. A number of risk factors which need to be considered while assessing the risk in health insurance and designing the insurance policy is depicted. The process of managing the risk in the insurance terminology encompasses the complex and systematic identification and treatment of risk, the process of risk reduction and

processes and structures that are directed into using opportunities while managing adverse events.

Keywords: risk, risk transfer, health insurance.

ZARZĄDZANIE RYZYKIEM I TRANSFER RYZYKA W UBEZPIECZENIACH ZDROWOTNYCH

Streszczenie

Ryzyko jest nieodłącznym elementem ludzkiego życia, a więc również i ludzkiej aktywności gospodarczej. Różne dziedziny nauki określają i rozumieją ryzyko na inny sposób, w zależności od swojej specyfiki, uniemożliwiając jednocześnie uniformizację jego zdefiniowania. Powoduje to współistnienie wielu definicji ryzyka.

Ubezpieczenie zdrowotne zostało zaprojektowane, aby chronić ludzi i ich działalność przed skutkami działań niepożądanych, które są wynikiem występowania ryzyka w przyrodzie. Kwestia ryzyka w ubezpieczeniach zdrowotnych jest przedmiotem badań przede wszystkim specyficznych warunków świata zewnętrznego. Zarządzanie ryzykiem stanowi jasne i uporządkowane podejście do jego szczegółowej identyfikacji. Celem zarządzania ryzykiem jest znalezienie najmniej kosztownej metody finansowania negatywnych skutków ekonomicznych dla poszczególnych rodzajów ryzyka w danych okolicznościach. W konsekwencji, efektem oceny ryzyka jest zróżnicowanie wysokości składki ubezpieczeniowej, w zależności od wymiaru ryzyka zachorowalności i śmiertelności.

W tym artykule omówione zostanie zagadnienie zarządzania ryzykiem i transferu ryzyka w ubezpieczeniach zdrowotnych. Zaprezentowana zostanie koncepcja ryzyka, poparta przez jego zrozumienie charakterystyczne dla myśli ekonomicznej oraz dla prawa ubezpieczeń. Przedstawione zostaną czynniki ryzyka, które muszą być wzięte pod uwagę podczas oceny ryzyka w ubezpieczeniach zdrowotnych i ustalania reguł polisy ubezpieczeniowej. Proces zarządzania ryzykiem w terminologii ubezpieczeń obejmuje złożoną i systematyczną identyfikację ryzyka, proces jego zmniejszania oraz procesy i struktury, które są skierowane na wykorzystanie możliwości, podczas radzenia sobie z działaniami niepożądanymi.

Słowa kluczowe: ryzyko, transfer ryzyka, ubezpieczenie zdrowotne.

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