

PUBLIC FINANCING OF HEALTHCARE SERVICES

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Abstract

Healthcare in Poland is mainly financed by public sector entities, among them the National Health Fund (NFZ), state budget and local government budgets. The task of the National Health Fund, as the main payer in the system, is chiefly currently financing the services. The state budget plays a complementary role in the system, and finances selected groups of services, health insurance premiums and investments in healthcare infrastructure. The basic role of the local governments is to ensure access to the services, mostly by performing ownership functions towards healthcare institutions.

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INTRODUCTION

Healthcare services are not a typical public good – they may be financed and performed both by the public and the private sphere. Yet due to the imperfect nature of the health service market, in most countries public authorities take at least some of the responsibility for the functioning of the healthcare system.

It is important to note that expenditure on health (from the point of view of the State) can be treated also as a good investment and not just a cost - arguments for this approach are based on the perspective of public health, economic and social welfare (Hnatyszyn-Dzikowska, 2012).

Also in Poland, based on art. 68 of the Polish constitution, public authorities have been charged with the duty to ensure to all citizens, regardless of their material status, equal access to healthcare services financed with public means in the statutory scope.

Healthcare infrastructure development shifted the problems of ensuring services, in the sense of physical access, away from the main focus. Issues of financing healthcare services became the primary problem.

Progress within medical technologies increases the range of available therapies, but also their costs. Demographic changes occurring in the society and pressure to improve service quality force the entities responsible for the system's construction to make difficult economic decisions. The third factor of rising costs is inflation in the sector of healthcare, which is generally higher than in others. (Jones, 2002).

In the Polish healthcare system, public means dominant. This is due to the authorities taking the responsibility for the systems' functioning. Despite that, the financing system is a certain mosaic, consisting of public sphere entities, mainly the National Health Fund, state budget and local government units. Each of those entities performs different tasks within healthcare.

The aim of this paper is to present issues related to healthcare financing from public means in Poland. The basic source of data for the analysis was a database published by the Organisation of Economic Cooperation and Development (OECD Health Data) and Polish sources:

- 1) budget Acts for the years 2004-2012 (ISAP),

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- 2) financial plans of the National Health Fund for 2004-2012 (NFZ),
- 3) National Health Accounts for 2006-2009 (GUS – Main Statistical Office),
- 4) basic healthcare data for 2005-2009 (Main Statistical Office),
- 5) Health and Healthcare in 2010 (Main Statistical Office),
- 6) price indices for consumer goods and services for 2003-2011 (Main Statistical Office).

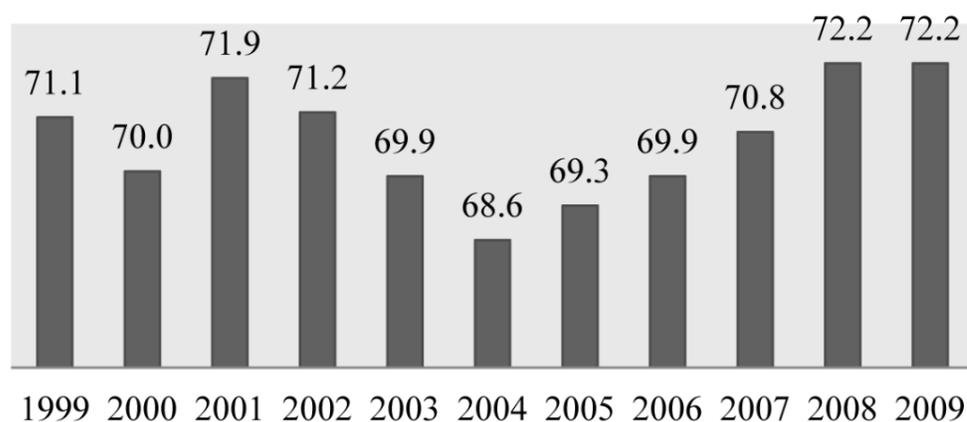
The problem of healthcare system organizations and funding seems to be essential. It provides an ongoing talking point in public debate in almost every country, and in Poland as well. Many Polish authors greatly contributed to this subject. Worth noticing are the publications of Ewelina Nojszewska, (Nojszewska, 2011) (Nojszewska, 2009), Jadwiga Suchecka (Suchecka, 2010), (Suchecka, 2011), Iga Rudawska (Rudawska, 2007), (Rudawska, 2011), (Rudawska, Urbańczyk, 2010), Kazimierz Ryć and Zofia Skrzypczak (Ryć, Skrzypczak, 2011a), (Ryć, Skrzypczak, 2011b), (Ryć, Sobczak, 2010). These papers present key terms of the healthcare market and concentrate on basic organisational and financial

problems of the healthcare system in Poland, Europe and worldwide organisations providing at the same time valuable and very detailed information. The financial aspects discussed in these papers refer generally to macroeconomics. The studies of Aldona Frąckiewicz-Wronka (Frąckiewicz-Wronka, Owczorz-Cydzik, Sobusik, 2004) (Frąckiewicz-Wronka, 2009b), Cezary W. Włodarczyk (Włodarczyk, 2010), Jerzy Leowski (Leowski, 2010) or Teresa Mróz (Mróz, 2011) also follow the idea of healthcare organization and financing.

HEALTHCARE SERVICE FINANCING FROM PUBLIC FUNDS

The healthcare financing model applied in Poland is based on a general health insurance system in which services are financed with obligatory premiums and The adopted conception of financing the services usually implies a considerable share of public means in the healthcare sector, although the insurance may be provided both by public entities and – usually on a smaller scale – by private entities. access to health services is connected with the fact of having insurance protection.

Figure 1: Public means' share in healthcare (in % of total expenditure) in 1999-2009

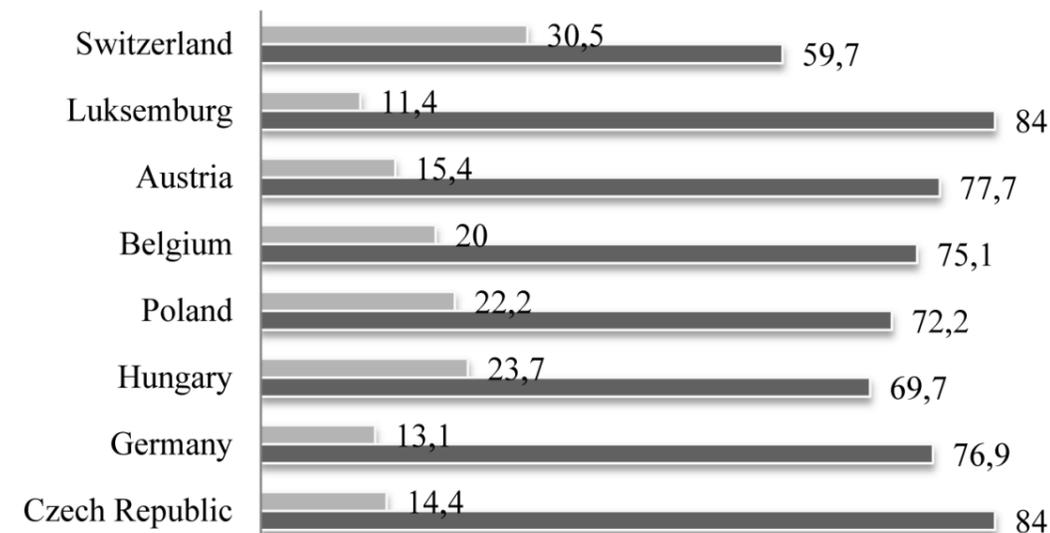


Source: Own analysis on OECD Health Data 2011 (www.oecd.org)

The adopted conception of financing the services usually implies a considerable share of public means in the healthcare sector, although the insurance may

be provided both by public entities and – usually on a smaller scale – by private entities.

Figure 2: The share of public means and out-of pocket expenditures in healthcare (in % of total expenditure) in selected countries in 2009



Source: Own analysis on OECD Health Data 2011 (www.oecd.org)

Despite the changes which have been taking place in the healthcare system since 1999 in connection with the intensive development of the private sector, the share of public means in healthcare oscillates at about 70% (72.2% in 2009) (figure 1). The rate corresponds to the average in OECD countries (71.73% in 2009). Yet comparing Poland to other countries in which healthcare is based on the general health insurance system, the share of public means is relatively low (figure 2).

The relatively low share of public means in the system is not a result of the abandonment of private health insurance – which is compulsory (which can be seen e.g. in Germany) – private health insurance in Poland is still only complementary towards the public insurance. Thus the high share of private means results mainly from households participating significantly in financing the services – in 2009 they made up 24%

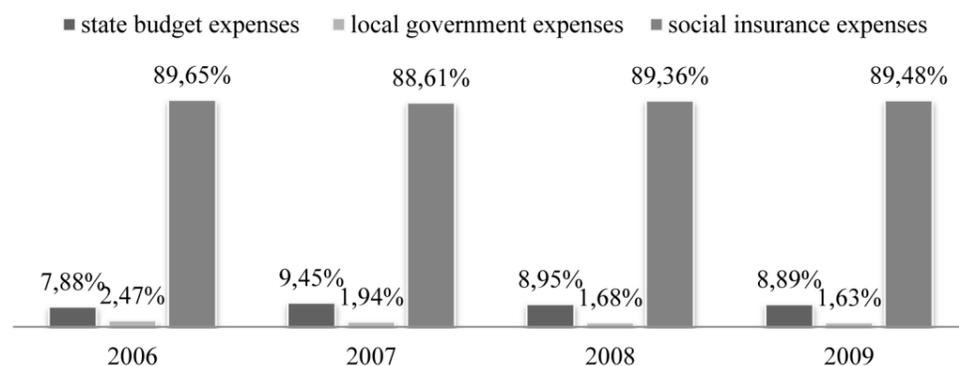
of current expenditure for healthcare. To compare, that share (out-of-pocket payments) in an analogous period in Germany was 13.1% (figure 2).

Public means in the Polish healthcare system come from three main sources:

- 1) social funds (National Health Fund),
- 2) state budget,
- 3) budgets of local government units.

A definite majority of the means are dispensed by the National Health Fund. In the successive years, they make up nearly 90% of all public means in the healthcare sector (89.5% in 2009). Other public means come from the state budget (8.9% in 2009) and local government budgets (1.6% in 2009). The structure remained constant in successive years (figure 3).

Figure 3: The share of public means from the particular sources in 2006-2009



Source: Own calculations based on National Health Account for 2006-2009.
Główny Urząd Statystyczny (www.stat.gov.pl)

The means of key significance for healthcare financing in Poland are the public means collected by the National Health Fund. The Fund functions as a state legal entity established with the Act on publicly funded healthcare services. The Act and the NFZ Statute constitute the legal framework for the Fund's Activity.

The basic task of the Fund is to manage the collected means for the people insured and entitled to the services. The main tasks of the Fund include:

- 1) defining the quality and availability of the services,
- 2) cost analysis,
- 3) contracting and financing healthcare services,
- 4) health promotion,
- 5) keeping the Central Register of the Insured.

FINANCING HEALTHCARE SERVICES FROM THE NFZ BUDGET

The main source of the fund's revenues are premiums for health insurance (with the due interest). Other sources, including donations, subsidies and financial revenues, are marginal from the point of view of financing the services. In the financial plan for 2012, state budget subsidies (for tasks related to medical rescue) made up a mere 3.19% of the Fund's net revenues, other revenues (including legacies and

donations) – 0.06%, and financial revenues (interest from deposits) – 0.05% of net revenues.

The amount of the health insurance premium depends on a few factors:

- 1) premium rate,
- 2) number of people paying the premium,
- 3) tax assessment basis.

The final revenues of the Fund are the outcome of the above. The possibility to influence their level is very limited, and only concerns the rate of the health insurance premium. The other elements which influence the premium's amount depend on the course of economic processes (GDP and inflation increase) and demographic processes that impact the number of people paying the premium and entitled to the services.

The health insurance premium is paid monthly and is indivisible. It is calculated based on the premium assessment basis. The statutory premium rate is currently 9% (in 1999-2012 it grew slowly from the initial 7.5%) (see table 1) and is partially tax-deductible – up to 7.75%. The remaining 1.25% is the tax-payer's additional charge.

Table 1: Rates of health insurance premiums in 1999-2012

Years	Premium rate	Tax-deductible premium rate
1999-2000	7.50%	7.50%
2001-2001	7.75%	7.75%
2003	8%	7.75%
2004	8.25%	7.75%
2005	8.50%	7.75%
2006	8.75%	7.75%
2007-2012	9%	7.75%

Source: Own presentation based on data of the Social Insurance Company (ZUS) (www.zus.gov.pl)

The right to healthcare services includes family members who are not otherwise bound to be insured¹. The insured person may apply for health insurance for their relatives, lineal descendants and spouse who are living in the same household. Covering household members with health insurance does not change the amount of the insurance premium (except for some farmers since 2012).

It is rather complicated to establish the assessment basis due to the variety of solutions in that area. The scope of this study does not allow an extensive analysis, thus only those solutions will be presented which concern how the premium basis for employees, people conducting businesses, and farmers is determined.

In the case of employees, the rules defining the basis for pension and retirement pension insurance premiums is applied. Remunerations are not excluded for periods of being unfit for work due to illness or limited to the amount equal to 30 times the value of the forecasted average monthly remuneration in the national economy for the given calendar year (as concerns premiums for pension and retirement pension insurance) (art. 81 item 5 of the Act). At the same time, the premium assessment basis is decreased by fees for pension, retirement pension and sickness insurance financed by the insured who do not pay the

premiums, which have been deducted by payers from the insured person's means (art. 81 item 6 of the Act). The basis for calculating the health insurance premium for people on disability allowance or retired is the amount of the health/retirement benefits they collect, excluding supplements, allowances, financial and non-financial benefits.

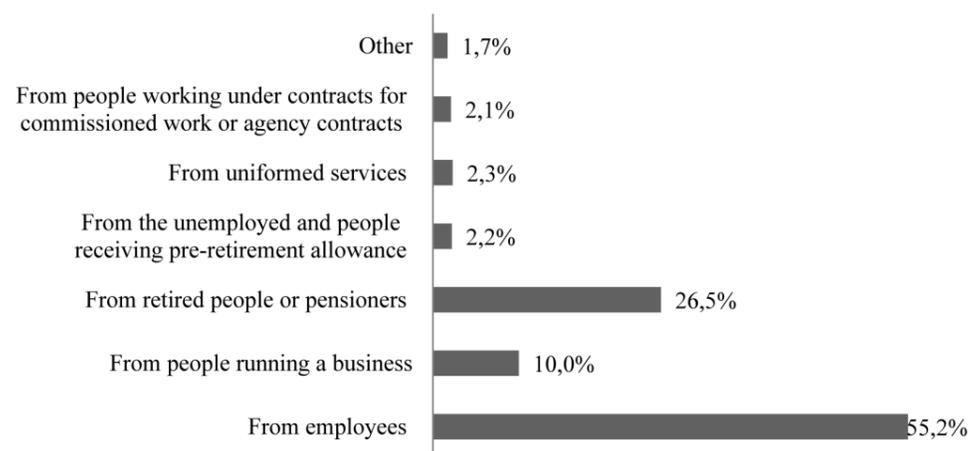
The premium assessment basis for people who run a business is established in a different way. In their case, the basis is the declared amount, but it cannot be lower than 75% of the average remuneration in the enterprise sector in the fourth quarter of the previous year. The current (February-December 2012) premium assessment basis is 2828.31.

Premiums charged from employees, people conducting business activity, pensioners and the retired, and premiums for people covered by other insurance the premiums for whom are paid by the state budget or other entities obliged thereto, excluding people who conduct agricultural activity, are recorded and transferred to the National Health Fund by ZUS.

Among the premiums collected by ZUS definitely the predominant means are those collected from employees (55% in 2009) and – 26% – from pensioners and retired people. Only 10% of revenues from health insurance premiums are means paid by people conducting business activity, who in a vast majority pay a premium calculated from the minimum declared basis (figure 4).

¹ And for people subject to specific types of insurance.

Figure 4: Structure of ZUS revenues from health insurance premiums in 2009



Source: Own calculation based on ZUS data (www.zus.gov.pl)

Much social controversy is aroused by how the health insurance premium basis is established for people conducting agricultural activity. Until the end of 2011, health insurance premiums of farmers were paid by the state budget (60% of KRUS [Agricultural Social Insurance Fund] revenues from health insurance in 2009) and were not related to the achieved income – except for people working in special branches of agricultural production, for whom the principles of calculating the premium are similar to those provided for people conducting business activity.

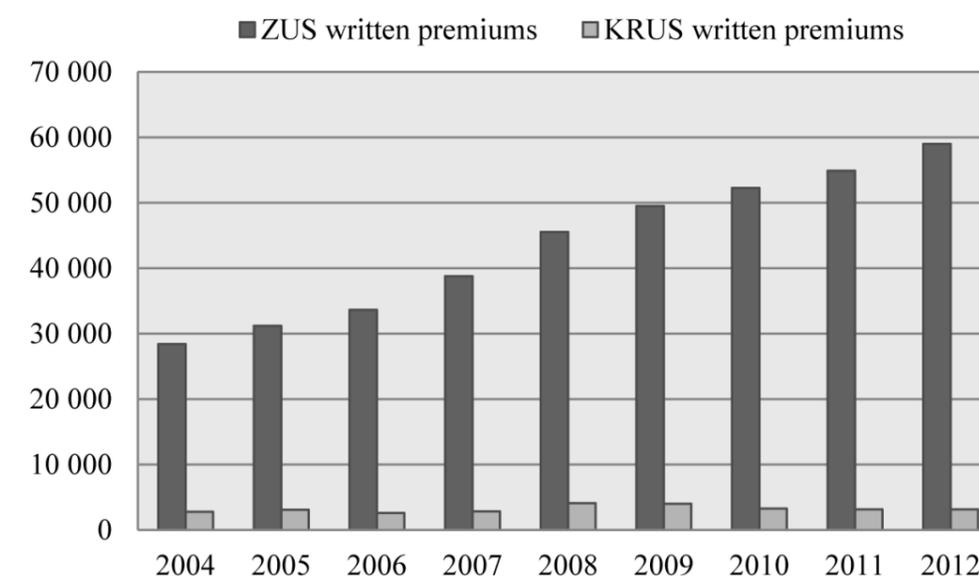
In connection with the ruling of the Constitutional Tribunal of October 2010, from 1st January to 31st December 2012 a new official way of calculating the health insurance premiums for farmers² was elaborated. The Act, which came into force on 1st February 2012, is of a transitory nature. The target solution is to include farmers in the general system. Following the new provisions, the premium amount is related – though in a limited manner – to the achieved income, and farmers (those who run farms of over 6 equivalent hectares and those in special branches) are charged for health insurance costs, which decreases the burdens of the state budget.

² Act of 13th December 2011 on health insurance premiums for farmers for 2012.

Currently, the health insurance premium for farmers (and their families) is calculated according to the following principles:

- 1) for farms of under 6 equivalent ha surface area – a premium of 1PLN/equivalent ha for a farmer and each household member is paid from the state budget,
- 2) for farms of over 6 equivalent ha surface area – a premium of 1PLN/equivalent ha is paid by the farmer for each insured person,
- 3) for farmers who run their activity within autonomous branches of agricultural production – the premium paid by the farmer is 9% of the declared income amount (no less than 9% of minimum remuneration), and for each insured household member – 9% of the basis amount, the basis being 33.4% of the average monthly remuneration in the enterprise sector as binding in the fourth quarter of the previous year,
- 4) if working on farms (of under 6 equivalent ha) and in special branches – the farmer pays the premium as specified in provisions for autonomous branches of agricultural production, and the state budget pays the premium for each insured household member on principles binding for farms of under 6 equivalent ha,
- 5) if working on farms (of over 6 equivalent ha) and in special branches, premiums are paid by the farmer as specified in provisions for autonomous branches of agricultural production, and premiums for household members are paid on principles binding for farms of over 6 equivalent ha.

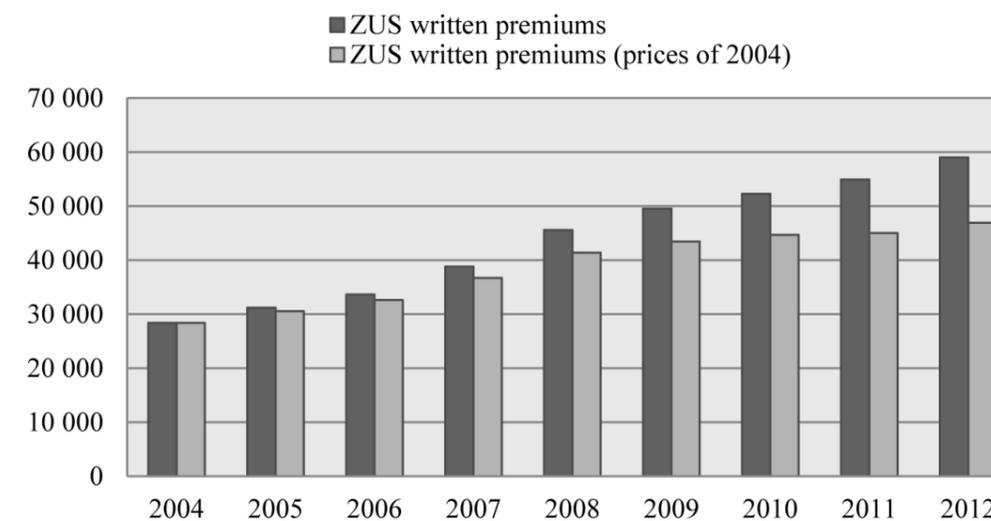
Figure 5: Health insurance premium according to sources in 2004-2012 in thousands PLN (current prices)



Source: Own calculation based on NFZ financial plans for 2004-2012

Premiums from people conducting agricultural activity, also those paid from the state budget, are recorded and transferred to the National Health Fund by the Agricultural Social Insurance Fund (KRUS).

Figure 6: Health insurance premiums collected by ZUS in current prices and constant prices as compared to 2004

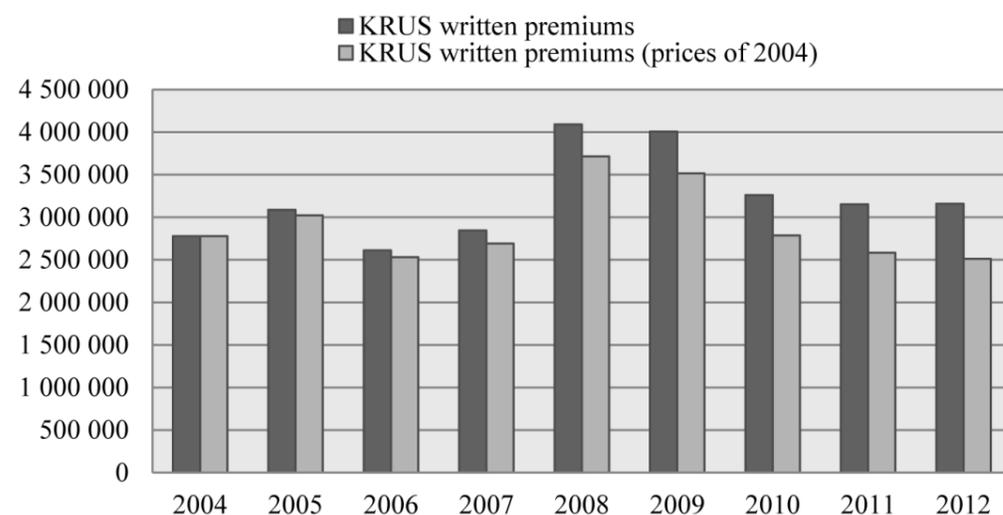


Source: Own calculation based on NFZ financial plans for 2004-2012 and GUS (Main Statistical Office) macroeconomic indices

Both ZUS and KRUS must transfer the collected premiums within 3 working days to the Fund's account. What is important, collection costs may not exceed 0.20% of the assigned premiums (in 2004-2011, premium collection costs oscillated between 0.19 and 0.21%).

In the NFZ income structure there definitely predominate premiums collected by ZUS. In 2011 they made up 94.6% of premium revenues. The NFZ revenue structure is shown in figure 5.

Figure 7: Health insurance premium transferred to NFZ by KRUS in 2004-2012 nominally and really (in prices of 2004)



Source: Own calculation based on NFZ financial plans for 2004-2012 and GUS macroeconomic indices

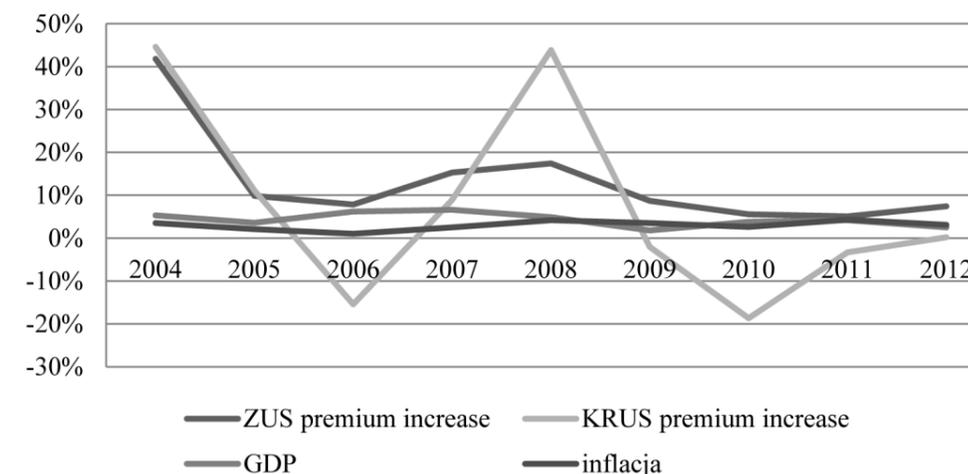
Revenues from premiums collected by ZUS – i.e. those coming mainly from employees and people running their own businesses – have a stable, constant growth tendency (due to the general increase of salaries in economy) both in current and in constant prices (from the level of 2004). In 2004-2011, the real growth of the written premium was 14.85 billion PLN (figure 6).

Revenues from health insurance premiums transferred to NFZ by KRUS show greater fluctuation (figure 6). In 2004-2011 nominal written premium remained comparable (with fluctuations of ten to twenty percent), except for 2008 and 2009, when a significant increase in revenues was observed. The real proceeds (adjusted by inflation indices and expressed in prices of 2003) from health insurance of

farmers in 2004-2011 fell by 173.7 million PLN (7.5% as compared to 2004).

Analysis of the growth pace of the premiums charged for health insurance (transferred by ZUS and KRUS) in relation to inflation and GDP growth shows that premiums collected by ZUS grew in the recent years (2004-2010) faster than inflation and GDP growth – particularly in 2007-2009. Premiums transferred by KRUS since 2009, and revenues from premiums have been growing slower than inflation and GDP indices.

Figure 8: Growth pace of health insurance premiums in relation to inflation and GDP growth



Source: Own calculation based on reports of the National Health Fund and data from the Main Statistical Office (GUS)

NFZ plays a key role in the Polish healthcare system as the entity which finances the services for the insured. The small share of private insurance companies in the health services market (0.6% of current expenditure for healthcare in 2008) ensures a monopolist payer position to the Fund. The scope of the financed services is defined legally and covers guaranteed services within the following areas:

- 1) basic healthcare,
- 2) outpatient specialist care,
- 3) hospital treatment,
- 4) psychiatric care and substance abuse treatment,
- 5) medical rehabilitation,
- 6) nursing and attendance services within long-term care and palliative and hospice care,
- 7) dental treatment,
- 8) health resort treatment,
- 9) supply of medical products,
- 10) drug and foodstuffs reimbursement.

To be financed by NFZ, a particular service needs to be qualified as a guaranteed service, which depends on an assessment based on the criteria of:

- 1) its impact on health improvement,
- 2) health policy priorities,
- 3) incidence, prevalence or fatality indices,

- 4) illness consequences leading to premature death, inability to work or lead a self-sustained life, or lowered life quality.

Important is also the clinically proven effectiveness and safety of the application, defined mainly through the ratio of the gained health benefits to health risk, and the ratio of costs to the gained health benefits.

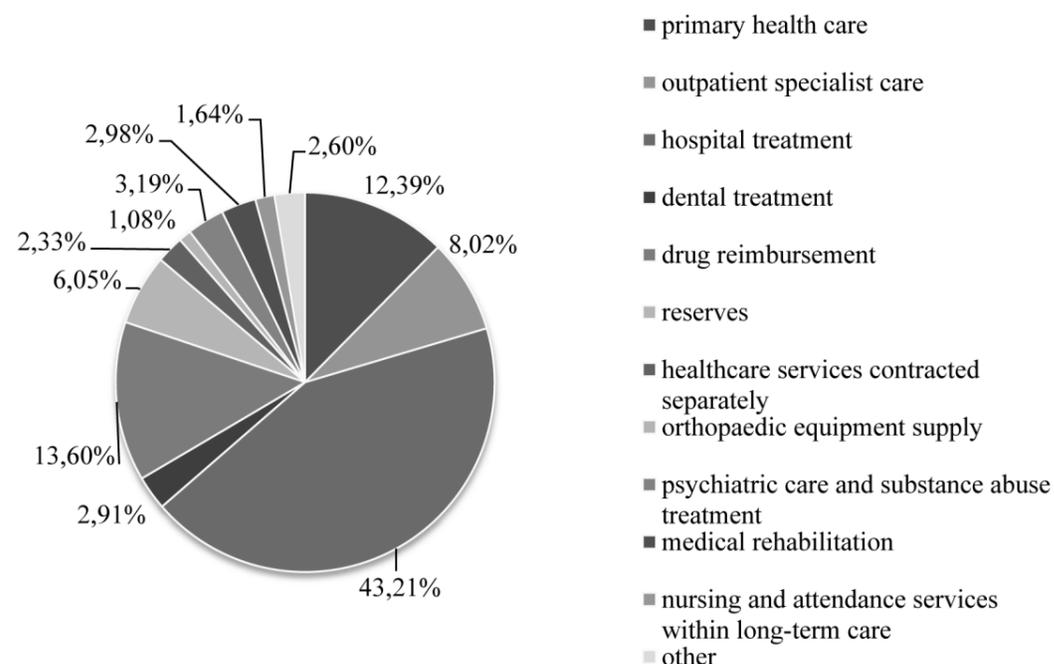
The entity whose task it is to assess healthcare services is the Agency for Health Technology Assessment in Poland, whose tasks include issuing recommendations on qualifying a healthcare service as a guaranteed service (or, removing it from the list of guaranteed services) and defining or changing the amount or manner of financing the guaranteed service. The detailed scope of the services is defined by directives of the Minister of Health – due to the progress in medical technologies, the basket of guaranteed services should be updated on a regular basis.

In the structure of NFZ expenditure for healthcare services (figure 9) there definitely dominate expenses related to stationary treatment, which claim about 45% of the means allocated to healthcare services (46.7% in 2011; 43.2% of expenditure planned in 2012). The next large group of expenses (about 15%) is drug reimbursement, and that is despite the relatively high participation of patients in financing pharmaceutical products. In 2008, households

incurred 61% of expenses for medicines and non-durable medical materials. The considerable costs of reimbursement enforced changes in the drug reimbursement policy, which entered into life on 1st

January 2012. About 13% of total expenses are costs of primary care services – the other groups of services constitute less than 10% of expenses each.

Figure 9: NFZ expenditure structure in 2012



Source: Own calculation based on the financial plan of the National Health Fund for 2012

The basic problem of financing healthcare by NFZ is the shortage of funds to cover the costs of medical services (Węgrzyn, 2012).

FINANCING HEALTHCARE SERVICES FROM THE STATE BUDGET

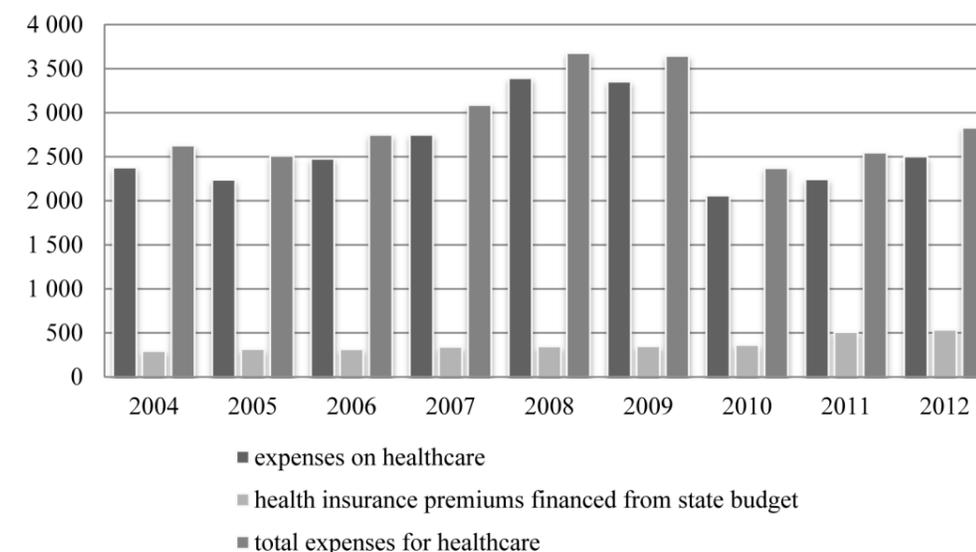
Despite establishing NFZ, whose task is to finance the services for the insured, some of the tasks within health protection are still financed from the state budget. Such tasks include financing:

- 1) health insurance premiums in cases specified in the Act on publicly funded healthcare services,
- 2) services for those who are not insured (e.g. in emergencies),

- 3) highly specialised services and health programmes,
- 4) tasks within medical rescue.

To analyse the total expenditure, information from budget Acts for 2004-2012 was used. The amount of expenditure on healthcare was specified on the basis of the amounts indicated in part 46 "Health", section 851 "Health protection" within the scope of current and investment expenses. The amount of expenditure on health insurance premiums and services for those not insured was specified based in chapter 85156 Health insurance premiums and services for persons not subject to obligatory health insurance (in all parts of budget classification).

Figure 10: State budget expenses on healthcare in 2004-2012 (in millions)



Source: Own calculation based on budget Acts for 2004-2012

Analysis of expenditure on healthcare services in 2004-2012 shows increased expenditure on health in 2007-2009. The increase was mainly due to the state budget taking over tasks related to financing medical rescue services, which had previously been contracted and financed by NFZ. Since 2007, tasks within medical rescue are financed from the state budget from means managed by voivods (provincial government) and the minister of health.

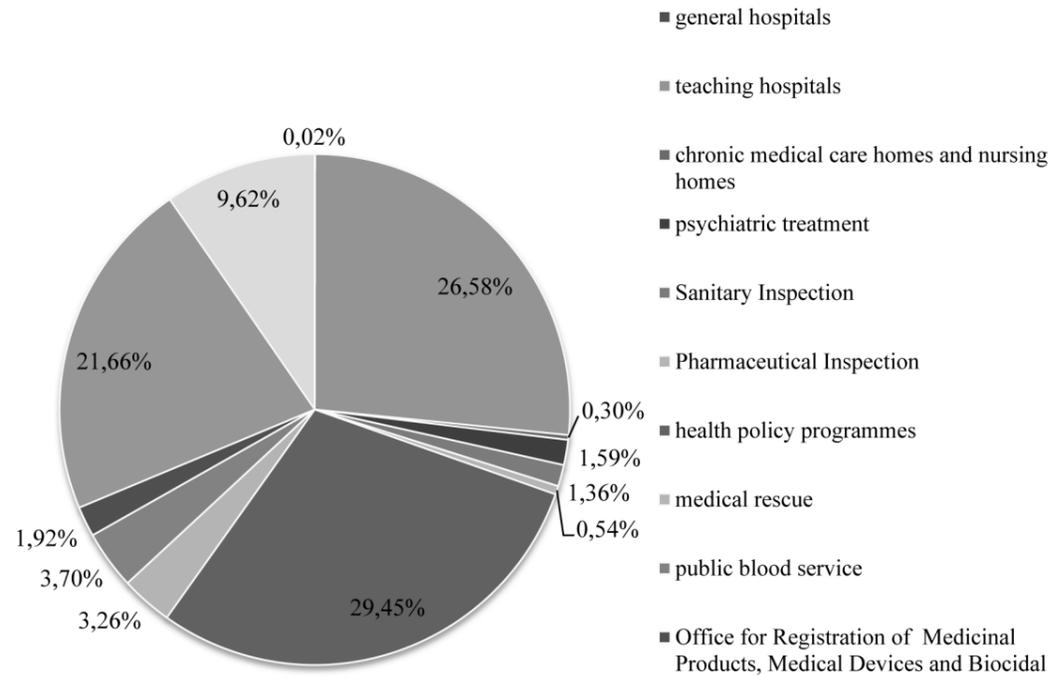
In 2010 expenses on healthcare decreased significantly. In 2012 they will amount to about 74% of the expenses of 2008. That decrease results from a considerable reduction of expenses on the State Sanitary Inspectorate tasks and mainly from significantly lower designated subsidies specified in the budget in the chapter "Other Activity", which

took 589 million PLN in 2009 (551 million PLN in 2008).

The basic tasks financed from state budget are as follows:

- 1) health insurance premiums,
- 2) services for those not insured,
- 3) health policy programmes,
- 4) highly specialised services,
- 5) medical rescue,
- 6) public blood service,
- 7) (sanitary, pharmaceutical, other) inspection tasks,
- 8) investment tasks concerning specialist and teaching hospitals.

Figure 11: Structure of expenditure on healthcare in 2012

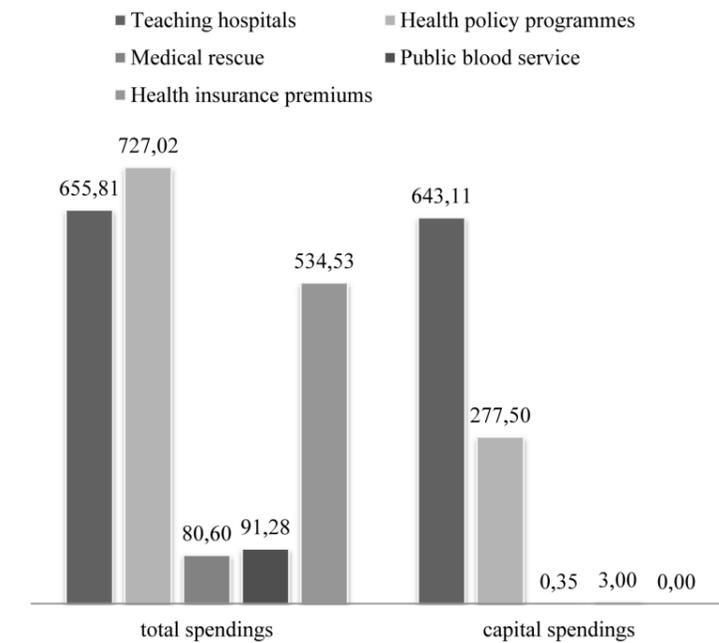


Source: Own calculation based on the budget Act for 2012

Figure 11 presents the structure of expenses on healthcare from the state budget in 2012. In this year, the greatest part of means transferred from the state budget was allotted to tasks related to realising health policy programmes – 29.06%. A considerable share of expenses in that group (38.17%) is made up of capital expenses (figure 12). Another important goal are tasks connected with teaching hospitals, which claim 26.22% of budget means. In that group of expenses, investment-oriented tasks dominate (98.06%). The third position as to significance in the state budget (within the analysed expenditure) is expenses on

health insurance premiums, which take 21.37% of the means and are exclusively current expenses. From the perspective of patients, important are the expenses on health programmes and specialist treatment. Nominal expenditure on highly specialist treatment – mainly transplants and selected cardiologic procedures – has been falling systematically since 2004 and is partly compensated with the Multiannual Programme “National Programme for the Development of Transplant Medicine”, a health policy programme.

Figure 12: Selected expenses in state budget for 2012 with capital expenditure indicated (in millions PLN)

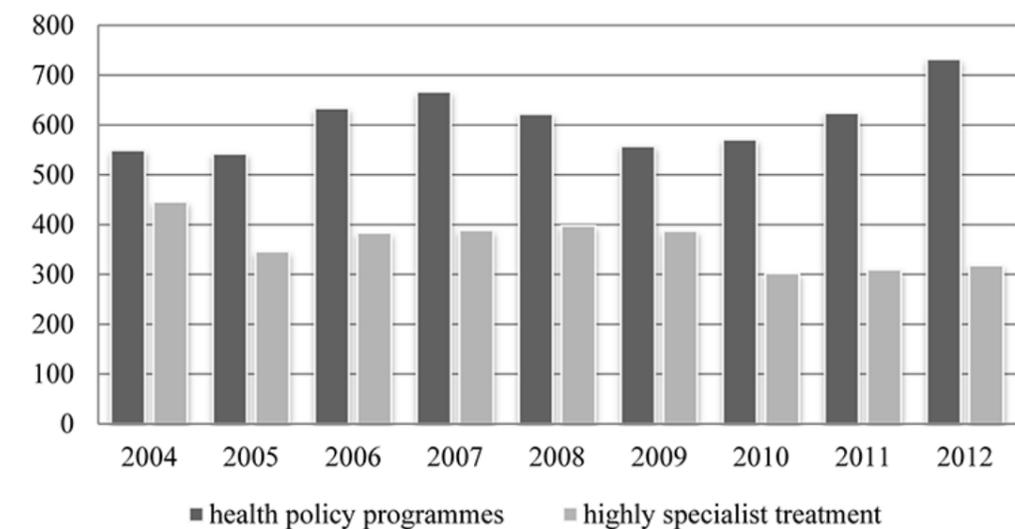


Source: Own calculation based on state budget for 2012

The expenses on health policy programmes has grown in 2012 (figure 13). The programmes conducted in 2012 cover tasks related to transplantology, psychiatry,

neonatology, stomatology, haematology, public blood service and issues of antibiotic treatment.

Figure 13: Financing health policy programmes and highly specialist treatment from state budget in 2004-2012 (in millions PLN)

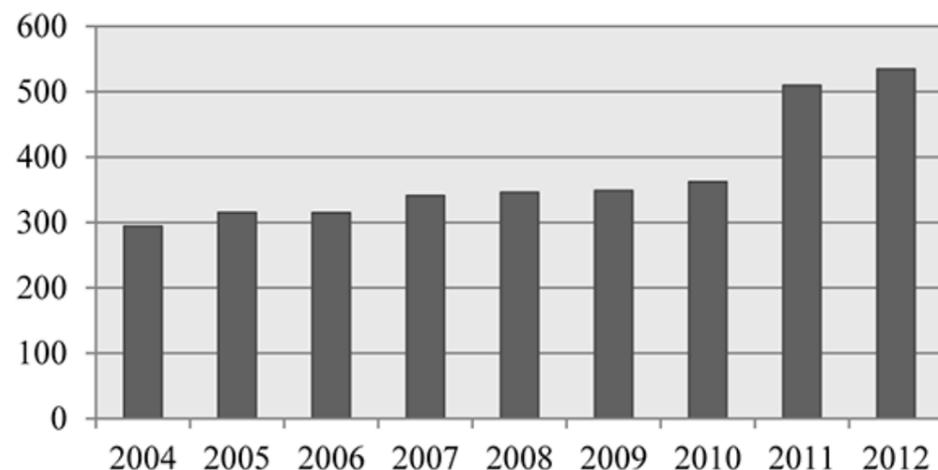


Source: Own presentation based on budget Acts for 2004-2012

Health insurance premiums and financing health services for the uninsured make up currently over 20% of budget expenses. The amount of means

allocated to those aims has significantly grown since 2010 (9.5% of expenditure in 2010 despite higher expenditure in total) (figure 14).

Figure 14: Health insurance premiums financed from state budget

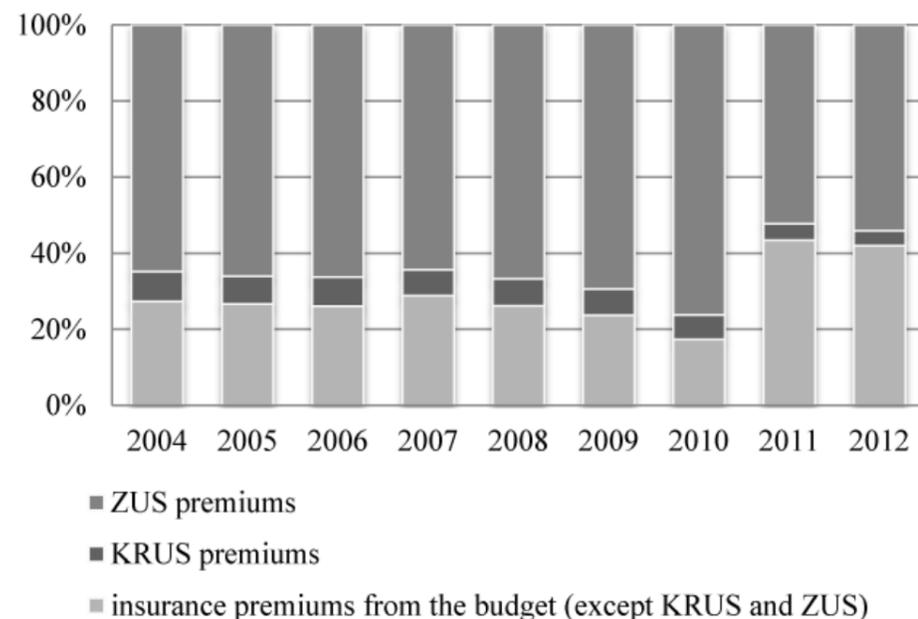


Source: Own presentation based on budget Acts for 2004-2012

Most means (54.07%) allocated to premium financing are transferred to NFZ by ZUS (figure 15). Means transferred by KRUS made up 3.93% in 2012. Means

managed by entities other than ZUS and KRUS, for example state budget (42% of expenses) are transferred to NFZ through ZUS.

Figure 15: Health insurance premiums financed from state budget



Source: Own calculation based on budget Acts for 2004-2012

In 2012, when implementing the performance budget in the state budget, healthcare tasks have been framed in five tasks within function 20. Health:

- 1) Task 20.1: Access to healthcare services,
- 2) Task 20.2: Medical rescue,
- 3) Task 20.3: Drug policy,
- 4) Task 20.4: Support for healthcare system development and restructuring,
- 5) Task 20.5: Sanitary and epidemiological supervision, prevention and health promotion.

For each task, sub-tasks and measures were defined, and indicators were specified to assess the degree of their performance.

FINANCING HEALTHCARE FROM LOCAL GOVERNMENT FUNDS

Local government units perform a wide range of tasks within healthcare, which include mainly:

- 1) creating and managing healthcare units (functioning as budget units or joint stock companies),
- 2) Acting as owners towards the existing SPZOZ (independent public healthcare centres),
- 3) health promotion by conducting local healthcare programmes, programmes of drug and alcohol abuse prevention,
- 4) financing health insurance premiums and healthcare services for people not subject to obligatory insurance.

Table 2: The tasks within the scope of the promotion and protection of health carried out by the LGU

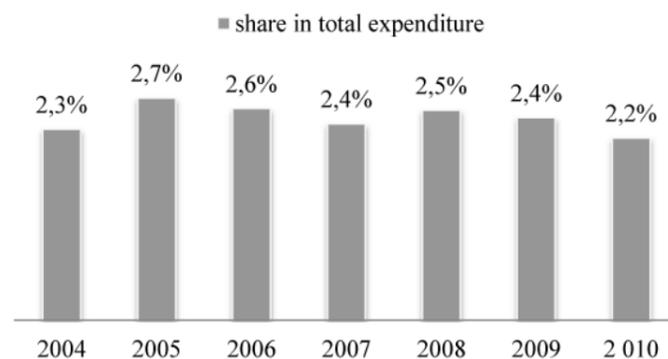
Voivodeship	County	Community
The development, implementation and evaluation of health programs - after consultation with the counties and municipalities	The development, implementation and evaluation of the effects of health programs, in consultation with municipalities	The development, implementation and evaluation of the effects of health programs resulting from the health needs and health status of the residents of the communities
Providing information about implemented health programs	Transfer of information about the ongoing health programs	Transfer of information about the ongoing health programs
The initiation and promotion of actions (healthcare services, health promotion) in terms of efficiency, including the restructuring process	The initiation and promotion of actions within the scope of health promotion and health education	The initiation and participation in formulating of local action concerning the harmful factors in the environment
Healthcare and health promotion	Healthcare and health promotion. Support for persons with disabilities	

Source: a study on the basis of: Książek, E. (2012).

Partnerstwo publiczno-prywatne w rozwoju podmiotów leczniczych. In I. Rudawska, E. Urbańczyk (Ed.), *Opieka zdrowotna. Zagadnienia ekonomiczne*. Warszawa: Difin

The comparison of tasks in the scope of the promotion and protection of health carried out by units of local government are shown in table 2.

Figure 16: Share of expenses on healthcare in local government unit (LGU) budgets in 2004-2009

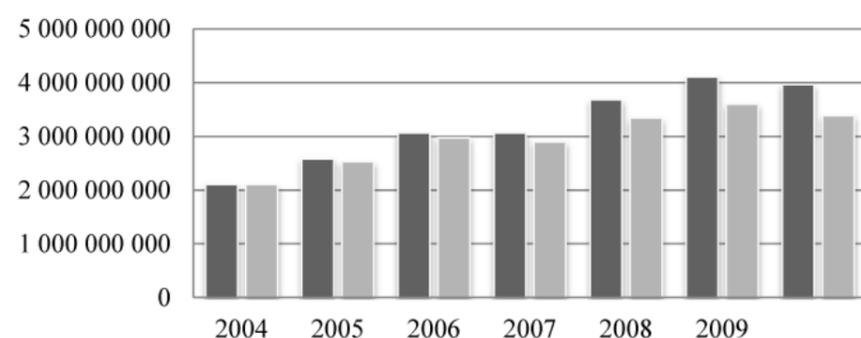


Source: Own calculation based on GUS data

Expenses on healthcare are not a substantial part of local government budgets. In 2004-2010, their share oscillated around the level of 2.2-2.7% (figure 16).

Despite that, a constant growth tendency is observed in the expenses, both as real and nominal values (figure 17).

Figure 17: Local governments' expenses on healthcare – nominal and real figures in 2004-2009

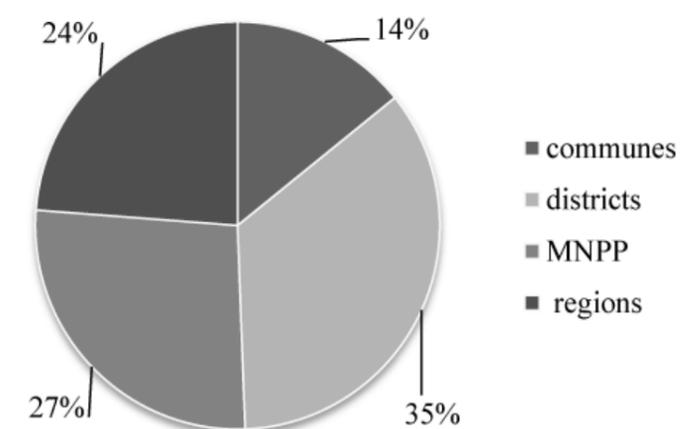


Source: Own calculation based on GUS data

The greatest share of the means allocated by LGUs to healthcare is spent by district (powiat) budgets (35.2% of expenses in 2010). A slightly smaller part (26.8%) is spent by budgets of cities with district rights (MNPP), which is related to the scope of tasks

of such units, which perform both commune (gmina) and district tasks. 23.8% of expenses of healthcare come from region (voivodship) budgets, and 14.2% from communal budgets (figure 18).

Figure 18: Structure of local government expenditure on healthcare in 2010

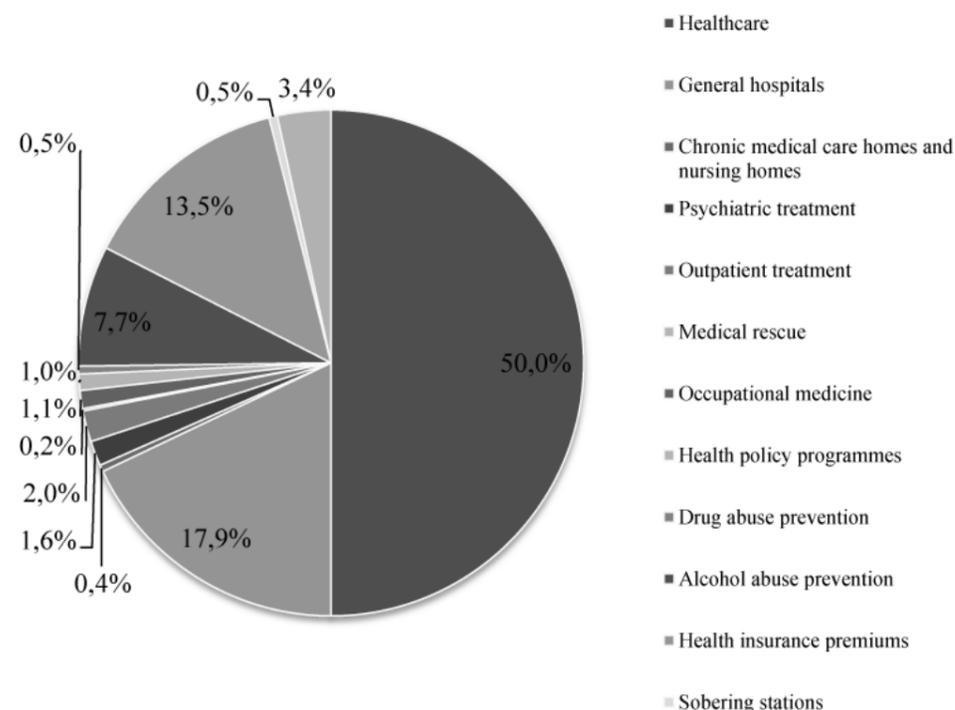


Source: Own calculation based on GUS data

Dominating in the structure of local government expenditure are expenses related to general hospitals, which make up nearly half of the means spent (46.14% of expenses in 2009) and which are borne mainly by districts and cities with district rights. Another large group of expenses is made up by health insurance premiums and healthcare services for people not

subject to obligatory insurance (20.93%). Those costs are also borne mainly by districts and cities with district rights. Another significant item on the list of local government expenses on healthcare are means allocated to alcohol abuse prevention (14.32%), paid mainly by communes and cities with district rights (figure 19).

Figure 19: LGU expenses on healthcare in 2009

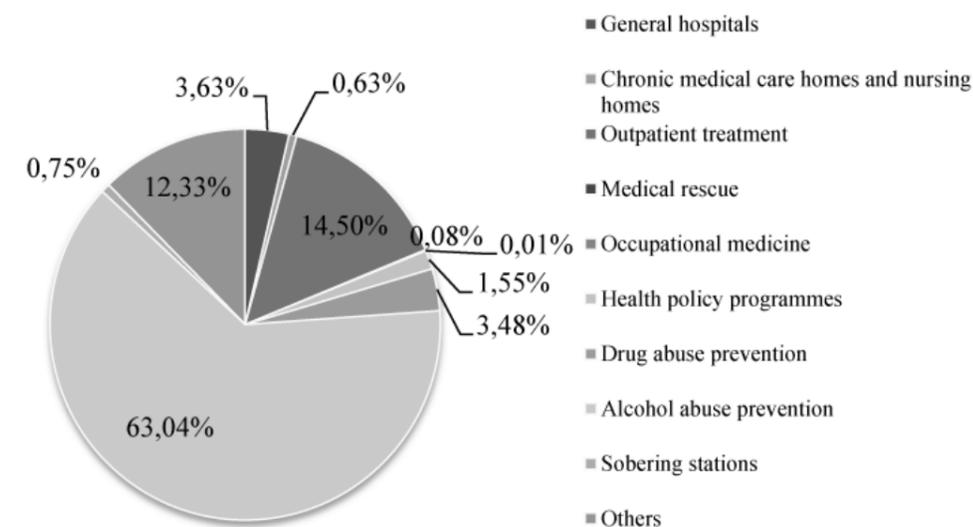


Source: Own calculation based on GUS data

From the perspective of financial expenditure, an important own task of the commune are Activities related to preventing and solving alcohol abuse problems (based on the Act of 26th October 1982 on upbringing in sobriety and counteracting alcohol

abuse as amended). The tasks are executed in the form of a communal programme for preventing and solving alcohol abuse problems, which is part of the social problem solving strategy passed each year by the communal council.

Figure 20: Communal expenses on healthcare in 2010



Source: Own calculation based on GUS data

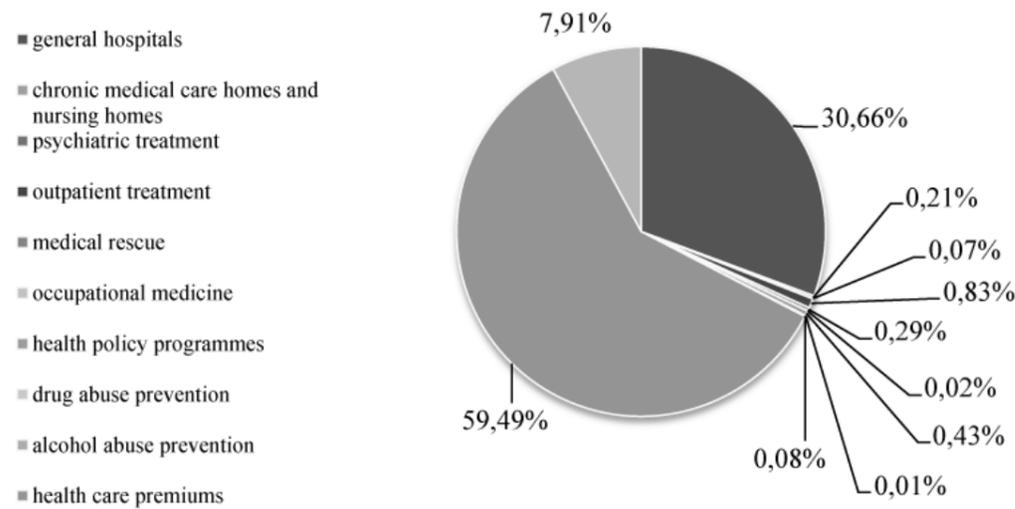
Figure 20 illustrates communal expenditure on healthcare in 2010. The greatest part of communal budget means was spent on tasks connected with alcohol abuse prevention – as much as 63.04%. 14.50% of the means were spent on outpatient treatment, 3.63% – on tasks related to general hospitals, 3.48% – on tasks within drug abuse prevention, and 1.55% – on health policy programmes. Other tasks are of marginal significance from the viewpoint of total expenditure (below 1%). In 2010 those tasks included e.g. sobering stations (0.75%), and chronic medical care homes and nursing homes (0.63%).

Districts execute public tasks at a supra-communal level, listed in a closed catalogue (Act on powiat

local government of 5th June 1998, Dz. U. of 1998, No. 91, item 578), including also tasks within health promotion and protection. Next to their own tasks, they execute a range of tasks commissioned under separate Acts. Thus the scope of tasks executed by districts results mainly from specific Acts, just like it is with communes. The main tasks include:

- 1) ensuring access to outpatient treatment,
- 2) conducting health policy programmes,
- 3) preventing and combating drug and alcohol abuse,
- 4) combating epidemiological threats.

Figure 21: District budget expenditure in 2010



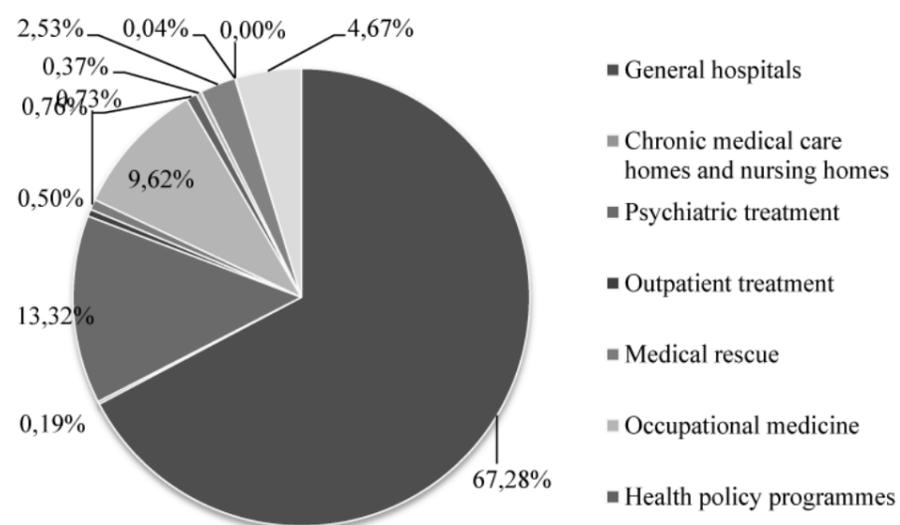
Source: Own calculation based on GUS data

District budget expenses on healthcare (figure 21) are focused on tasks related to the activity of general hospitals, which took up 30.66% of the general means in 2010, and on financing health insurance premiums (mainly for the unemployed). The premiums cost the districts 59.49% of the means in 2010 (yet this task is not financed from the districts' own resources, but from designated subsidies). Each of the other tasks takes up less than 1% of healthcare-related expenses. These include outpatient treatment (0.83%), health

policy programmes (0.43%), medical rescue (0.29%), chronic medical care homes and nursing homes (0.21%).

Cities with district rights, i.e. communes which also execute district tasks, are a different category in the statistics. The greatest part of the budgets of those cities was allocated in 2010 to the following tasks: general hospitals (67.28%), psychiatric treatment (13.32%), occupational medicine (9.62%) and alcohol abuse prevention (2.53%) (figure 22).

Figure 21: District budget expenditure in 2010



Source: Own calculation based on GUS data

Regional (voivodship) governments perform their tasks based on the Act of 5th June 1998 on voivodship government (Dz. U. of 2001, No. 142, item 1590 as amended). These are statutorily specified tasks of regional character, particularly as concerns health promotion and protection. Just like in the case of other LGU levels, the list of tasks is the product of a range of statutory regulations, and covers e.g.:

- 1) ensuring access to outpatient treatment,
- 2) conducting health policy programmes,
- 3) preventing and combating drug and alcohol abuse,
- 4) combating epidemiological threats,
- 5) occupational medicine.

Ensuring equal access to healthcare services by performing ownership functions concerning healthcare infrastructure must be viewed as the main role of local governments as concerns healthcare. Next to a range of organisational duties, it means the local governments' liability for the poor financial situation of SPZOZ, as defined in the Act on medical activity of 5th April 2011 (Dz. U. of 2011, No. 112, item 654). The occurring commercialisation (transforming SPZOZs in commercial companies) brings no major changes from the perspective of the local governments' financial liability – as the owner of a hospital in the form of a commercial company, the local government is still liable for damages, although in the case of such a company, recovery proceedings are possible.

Another important financial burden for local governments is the need to adjust the existing infrastructure to the requirements given in the directive of the Minister of Health of 2nd February 2011 on requirements that should be met in professional and sanitary aspects by premises and equipment of healthcare units (Dz. U. of 2011, No. 31, item 158), which will require incurring considerable investment costs. In project justification, the Ministry of Health was unable to assess the financial effects the

regulation would have on the state budget and local government budgets.

CONCLUSIONS

The healthcare financing model adopted in Poland implies considerable participation of public means in the system. The legislator has imposed on public entities a wide range of tasks, which include not only financing healthcare services, but also ensuring equal and common access to healthcare benefits.

The basic entity operating within the public sector is the National Health Fund. It finances the services for the insured on the basis of general health insurance premiums.

The state budget plays a supplementary role in health service financing, most of all within the scope of highly specialist services and health policy programmes.

Local governments execute different tasks in the system. Their basic role is to ensure access to health services by performing ownership functions towards healthcare centres.

The relatively low expenditure on healthcare, together with high expectations of society, constantly bring the sector's problems into the focus of public debate. Social pressure enforces constant changes, which often bring chaos and a sense of destabilisation both in medical circles and among patients.

The main directions of reforms are deemed to be: rationalising resource management, commercialising, and implementing management tools typical for the private sector in the public sphere, which seems to be necessary, taking into consideration the budget limitations.

Health financing reforms, though reasonable in context of efficiency and availability, usually lead to changes in funding rules. The efforts to reduce the liability of the State lead to increased responsibility of beneficiaries of healthcare services (Węgrzyn, 2012).

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