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Abstract of a Ph.D. thesis
"Public sources of healthcare financing in Poland"

The subject of the Ph.D. thesis were public sources of healthcare financing in Poland. This does not include the problems of private sources of financing as those do not fall under the branch of financial law.

The Polish healthcare system has not got a single source of financing that would provide funds for fulfilment of its duties. The financing model currently in place is based primarily on the proceeds of the National Health Fund[1] which are ensured through collection of health insurance contributions. Public sources of healthcare financing also include the state budget and the budgets of local government units. The scope of healthcare tasks imposed on the state and local government units determines their duty to provide funds for the fulfilment of those duties. Non-repayable EU funds, which are distributed as financial support for the performance of healthcare tasks under national and regional operational programmes, are also of some significance.

The choice of the subject of the thesis was dictated by the need to investigate the theoretical and practical aspects of public sources of healthcare financing in Poland. Another reason was the absence of monographic as well as fragmentary papers on the subject and the social significance of the problem.

The main aim of the paper was to establish whether regulations at law that determine the types of public sources of financing secure the performance of healthcare tasks. Further to this aim, the thesis was divided into chapters. Each chapter is dedicated to one specific aim.

The aim of chapter one was to establish the objective scope of the thesis through determination of the meaning of the concepts basic to the studied problems, which make up the title of the thesis. The chapter also defines the normative criteria of classification of sources of healthcare financing and presents such classification. There is also a specification

[1] Further referred to as "NFZ" or "the Fund".

of generally applicable laws which govern the rules of acquisition and spending of public funds on the performance of healthcare tasks.

It was established that public sources of healthcare financing are those whose legal construct is determined in line with public law norms. Such sources include public funds that come from or feed financial resources whose accumulation and spending is included in the notion of public finance.

Further to the adopted definition of "public sources of healthcare financing", the thesis analyses financial resources employed to finance the healthcare tasks of the state and local governments as well as the legal form of spending public funds coming from the state and local government budgets. The thesis also looks at a health insurance contribution as a public source of healthcare financing. The thesis does not cover income and gains of the state budget and local government budgets allotted for general public spending in line with the principle of material unity of the budget (e.g. income derived from taxes and local fees).

The specific aim of chapter two was to look at the evolution of the sources of healthcare financing. With that, the reasons for the departure from the budget model and turn to national health insurance were established.

The historical and legal analysis indicated that the mode of healthcare financing has undergone significant transformation. During the interwar period healthcare was inseparably linked to sickness and maternity insurance. Health insurance contributions constituted a source of financing for healthcare services but also services associated with the risk of development of a disease, which did not concern directly healthcare services. After World War II healthcare was clearly separated from the social insurance system. The expenditure on healthcare was incorporated into the state budget. The state budget became the main and only source of healthcare financing.

As a consequence of economic reforms and changes of the political system, the healthcare system based on health insurance was restored. The health insurance contribution again became the primary source of healthcare financing. Nevertheless, the other sources of financing, i.e. state budget and local government budgets, were left in place.

The aim of chapter three was to present and analyse particular models of healthcare, including the Bismarck model, the Beveridge model (National Health Service) and the socialist model. The healthcare models applied in Europe are based on the principle of social solidarity. They allow every citizen to use healthcare services regardless of their financial

status. Under such systems, public authorities guarantee universal access to healthcare services. In developing their healthcare systems, EU member states drew from the original models of healthcare organisation and financing and adjusted them to their social and political situation. This is what happened in Germany, the United Kingdom and Italy.

Chapter four of the Ph.D. thesis focused on the subjects of the healthcare model applied in Poland. The first aim of the chapter was to establish the area of competence, the structure and the principles of financial management of active entities operating within the healthcare system in Poland, including such entities which are in charge of management, financing and supervision as well as providing healthcare services. The other aim of the chapter was to formulate a list of passive entities, i.e. patients entitled to benefit from the healthcare services financed with public funds, with specification of the subjective scope of compulsory and optional health insurance, as it determines the subjective scope of the health insurance contribution.

The analysis of the organisational structure of the healthcare system applied in Poland points to diverse positions of the entities operating within the system and diverse legal nature of their tasks. As the organiser of the healthcare system, the National Health Fund is in charge of providing all the insured with access to guaranteed services. The Fund, however, is not a direct provider of the services. Local government units and state administration bodies also play an important role as they fulfil and finance public healthcare tasks.

Under the Polish system, entities that carry on medical activity assume the role of healthcare providers. Their financial situation is contingent on the amount of funds allotted for the performance of tasks commissioned by way of a contract with NFZ.

In light of the list of titles that give rise to an insurance obligation it seems reasonable to assume that the health insurance system covers nearly everyone who is entitled to healthcare under Art. 68 Sec. 1 & 2 of the Constitution of Poland. The analysis of the subjective scope of compulsory and optional health insurance revealed that the entities obligated to pay contributions are essentially natural persons having a status of the insured. Nonetheless, some persons are not obligated to pay contributions from their own funds. There are specific groups of the insured whose contributions are paid from public funds.

The next two chapters look at the legal problems associated with health insurance contributions as the main source of healthcare financing in Poland.

Chapter five analyses particular structural components of the health insurance contribution viewed here as a kind of a public levy, and the legal aspects of payment of the contribution by the obligated entities. The aim of the study was to establish the basis for assessment of the health insurance contribution and its rate, which significantly determine the amount of the contribution, taking into consideration the problem of the so-called concurrence of insurance. The legal construct of the health insurance contribution has not been separately regulated in section IV of the Act on healthcare services. In the majority of cases the method of calculation of the basis for assessment of the contribution depends on the legal construct of the retirement contribution and disability insurance contribution and the personal income tax.

The basis for assessment of the contribution has been established erroneously and it has a negative effect on the entities covered by the health insurance. Certain groups of the insured are discriminated against, including the group of employees and contractors. It also affects the scope of public liabilities of entrepreneurs whose revenues from business remain below the minimum basis for assessment of their contribution. In terms of the health insurance obligation, the most privileged social group are farmers. The scope and amount of public liabilities of farmers are different from those of other groups of citizens and call for considerable changes that should cover the rules of establishment of the amount of health insurance contribution. By making the basis for assessment of the contribution of all the groups of insured who earn revenues from a given insurance entitlement (e.g. entrepreneurs and farmers) contingent on their ability to pay, we could considerably increase the revenues of NFZ.

The consequences of misshaped rules of establishment of the amount of health insurance contribution, which differentiate the scope of insurance liabilities of persons subject to compulsory insurance, affect not only such persons. It was established that the revenues derived from health insurance contributions are not sufficient for the National Health Fund to ensure that the healthcare system runs as it should. Furthermore, the errors have a considerable impact on the mode and scope of financing of healthcare tasks of the state and local governments with funds from the central budget and budgets of local government units.

The change of the method of establishment of the amount of health insurance contribution would not fundamentally affect the scope of public liabilities of the insured on account of the ability to deduct a significant portion of the health insurance contribution from the amount of due personal income tax.

Chapter six aims to define the legal nature of the health insurance contribution. It was established that the legal construct of the contribution is such that the contribution can be deemed a public levy, as defined in Art. 217 of the Constitution of Poland. The study revealed that the health insurance contribution is a standalone public levy that constitutes a public, national, general, non-refundable and compulsory pecuniary obligation imposed pursuant to the provisions of the act, with a paid and purpose-oriented nature, allocated for the performance of constitutional healthcare tasks of the state by the National Health Fund under national compulsory or optional health insurance. In light of the adopted definition, it seems reasonable to assume that the health insurance contribution is a specific kind of a public levy and it cannot be identified with other similar obligations, such as the institution of a tax due to its purpose-oriented and paid nature. A comparison between the health insurance contribution and public levies other than tax (social insurance contributions and fees along with surcharges) does not reveal any similarities that could result in the said obligation being treated like a referent of any of the levies listed. Aside from features which are essentially common to all the public levies, some of the above-mentioned levies have a paid and purpose-oriented nature. The intended application and function of such levies are different, though.

Chapter seven looks at the expenditure from the budgets of local government units and the state allotted for the performance of public healthcare tasks. The aim of this part of the paper was to establish the extent to which the budgets are burdened with healthcare financing, and to analyse the extent to which applicable regulations at law protect the fiscal interests of the state and local governments with respect to their obligation to finance the performance of the tasks imposed on them.

It was established that the scope and types of public expenditure derived from local government budgets have not been structured properly. Doubts surround primarily the obligation of local government units to offset the loss of independent public healthcare organisations or take over their liabilities in case of their liquidation. This kind of expenditure has a negative effect on the ability to plan an optimum budget. The amount of expenditure provided for clearing the debts of independent public healthcare organisations is relevant in light of the fiscal rules aimed at limiting the indebtedness of local government units included in the Act on public finance.

The local government sector is left facing the problem of increasing indebtedness of healthcare organisations without any significant financial support on the part of state administration bodies responsible for the establishment of the rules of financing and shape of

the healthcare system. In allowing for financing of guaranteed healthcare services from local government budgets in addition to the obligation of financing other tasks of local government units associated with healthcare, a portion of the responsibility for the operation of the system is transferred to local governments. In spite of this, local government bodies have no impact on the rules of its organisation and financing. As a result, the budgets of local governments are burdened without any increase in their own income, and there is no guarantee of uniform rules of providing healthcare services, which casts doubt on the compliance of the applicable regulations with the Constitution of Poland.

The increase in the number of healthcare tasks of local government units is an evidence of the search for new solutions in the area of healthcare financing, which could lower the expenditure of the state and the National Health Fund. The shift of the responsibility for financing the healthcare system onto local government units could be an indicator of the fact that the sources of healthcare financing have in fact been shaped erroneously.

In this section of the paper it was established that the National Health Fund is allotted funds from the state budget for certain healthcare services, in the form of earmarked subsidies. The costs actually incurred by NFZ in performance of specific tasks are not relevant to the amount of subsidies granted to the Fund. As a result, it might be necessary to allocate additional funds to ensure proper performance of the healthcare services, even though they should be financed entirely from the granted subsidy.

The fact that healthcare services are financed with funds from the state budget and local government budgets supports a thesis that the Polish healthcare financing system is not entirely consistent with the insurance model. It is merely based on the insurance method of healthcare financing.

The aim of chapter eight was to investigate the ability to finance healthcare with EU funds. The analysis covered the subjective and objective scope of particular operational programmes which provide for financing of projects that involve healthcare expenditure under 2014-2020 financial perspective.

A vast majority of the funds derived from national or regional operational programmes are intended to be distributed between beneficiaries that provide healthcare services financed with public funds or intend to do so once they receive the EU support. An overwhelming majority of beneficiaries that can pursue projects under particular priority axes related to healthcare, are public organisations. Such a subjective scope of beneficiaries of EU funds

practically prevents private sector healthcare organisations from applying for financing under operational programmes.

Nevertheless, EU funds do not constitute a significant source of healthcare financing in Poland. The burden of healthcare financing falls on the state, not the EU. The sum of funds derived from operational programmes is insignificant compared to the total amount of EU funds intended for allocation under such programmes.

A diverse array of public sources of healthcare financing fails to provide a financial guarantee of performance of the tasks of the state in that respect from the point of view of patients. The findings made under the study revealed that the normative structure of legal and financial institutions that determine the shape of public sources of healthcare financing in Poland and some of the relations between them are off. The funds derived from the sources covered by this study are not sufficient to ensure proper performance of public healthcare tasks.

The changes in the structure of healthcare financing sources are only short-term solutions and they do not lead to any meaningful increase in expenditure derived from public funds. As a result, patients are compelled to invest their own money to gain access to quality healthcare, even though the Constitution of Poland guarantees access to healthcare services financed with public funds to everyone regardless of their financial situation.

For the foregoing reasons, the thesis contains a number of conclusions with a view to the future law. One of the most important suggestions is to make the calculation of the basis for assessment of the health insurance contribution paid by farmers and entrepreneurs contingent on their individual ability to pay, and to give up financing of some healthcare tasks with the funds from the state budget through changes in the legal construct of the contribution that could decrease the income of the state derived from personal income tax in favour of increasing the revenues of NFZ derived from health insurance contributions.

The Ph.D. thesis has been completed in line with the legal dogmatic method supplemented with legal historical method and comparative legal method.

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