Poland: will legal restructuring affect the (real) economy of hospitals?

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In Poland, major restructuring of health care facilities started in the early 1990s, when a law on health care units was introduced. By virtue of this law, health care institutions have been separated into two legal structures: public but autonomous ‘SPZOZs’ and non-public NZOZs.

Prior to the introduction of this legislation public health care units had been operating as, ‘budgetary units’, fully owned and dependent on their public ‘mother administration’. However, this form of operation had been considered ineffective, with burgeoning bureaucracy and debts, whilst delivering poor patient services, leading to the decision to make all public health care units autonomous units (SPZOZs).

Since 1995 the new public health care units were established at different public administrative levels (municipal, county, regional or central) and the non-public units by other private sector bodies, including foundations.

Instability and insolvency protection

Structures have been changing gradually. Formally, one key difference between the old budgetary units and the new SPZOZs is that the latter are registered in a dedicated chapter of the national legal register and have a similar legal status to companies and foundations. However, unlike other legal entities on this register, SPZOZs are protected from bankruptcy. They are autonomous in management but should financial difficulties arise, liability rests with the public authorities. This guarantee was intentionally introduced in the 1990s, as Parliament wanted to prevent the sudden collapse of health care facilities considered important for the maintenance of public health.

In subsequent years of operation, it became obvious that, while this mechanism protected these health care facilities, it hampered their business partners, such as medical and fuel suppliers. Moreover, managers of the SPZOZs, aware of their special position, often spent more than their units’ revenues permitted for, increasing the level of debt. Despite governmental efforts to clear and restructure hospital debts, many SPZOZs have continued to build up deficits. In the period since 1998, the state spent more than €3 billion (12 billion Zlotys (PLN)) on debt bailouts. In 2008 alone cumulative debt amounted to €1.5 billion, compared to a total health budget of approximately €14 billion (50 billion PLN).

Without appropriate incentives to control costs, the SPZOZs threaten to seriously destabilise the finances of local administrations. In this respect, it appears to be absolutely necessary to undertake further action. It is worth noting, however, that the distribution of debt is uneven; 80% of the accounts payable by SPZOZs were generated by 10% of the units. Of 1,730 units examined by the Ministry of Health, 828 did not have any outstanding debts (47.9% of all SPZOZs surveyed).

Privatisation

Since the 1990s privatisation has been undertaken, to a large extent, in the ambulatory care sector, and today the majority of ambulatory health care providers have been converted into NZOZs. It was commonly perceived that private ownership of ambulatory care results in better care, more flexibility and more dedication of providers to maintain good relationships with their patients. Privatisation has not limited access to public services, as private providers have been fully integrated into the public health care system and largely operate on the same principles. Moreover, privatisation of ambulatory care has not been linked with any significant sale of property: local administrations continue to own properties, renting space to companies staffed by former SPZOZ employees.

The beginning of the new millennium marked the first attempt to ‘restructure’ hospitals by changing their legal structure. Unlike ambulatory health care, the majority of the population has remained suspicious of the privatisation of hospitals. The process of privatisation in general, let alone hospital privatisation, has had little support.

Nonetheless by the end of 2006, there were approximately 150 hospitals run as NZOZs, including fifty established by companies owned by local governments. These latter entities were established, in most cases, as a result of ‘closing down’ the public facility (SPZOZ) and creating NZOZs established by a company and owned partially or fully by local government.

From the legal perspective, these new entities were ‘non-public’, established by limited liability companies. However, since the shares are mostly owned by local authorities, it is difficult to talk of privatisation in this context and the term ‘non-public health care institution’ does not really apply.

All hospitals owned by companies run by local governments are contracted by the National Health Fund and their scope of services is similar to the previous SPZOZs. This seemingly obvious statement is important because, in the eyes of the public (and indeed that of some political forces), a change in the legal status to ‘non-public’ is synonymous with ‘payment for services’. This is, of course, untrue. Only a handful

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of the fifty restructured hospitals encountered difficulties after the change and most experienced an improvement in their financial and management situations.

Following the initial success of restructuring, the government was inspired to push for a universal change of status in hospitals from SPZ OZ to NZOZ. In 2008 the government formulated a programme, initially proposed as a law, which required each SPZ OZ to transform itself into a company owned by the local community.

Governmental plans had scheduled this to be completed by the end of 2010. However, the obligatory nature of the process and tight timeframes were major reasons for political opposition to the proposal. Accompanied by populist rhetoric, calling for “state responsibility for citizens’ health”, this opposition was strong enough to force the President to veto the law.

In these circumstances the government undertook steps to encourage hospitals to change by using financial incentives, including debt bailouts and special credit lines for investments. According to very conservative estimates, at least seventy hospitals (of 650), will respond positively to this offer. Many more are however likely to wait for even more generous offers from future governments.

The reform of health care facilities in Poland has hardly begun. We face further challenges and are likely to see more extensive liberalisation of markets in health care. Opposition to this reform, coupled with the traditional budgetary attitude of health care decision makers, remains strong, and this will exclude and isolate many units. Another round of changes is expected in the next few years, when the government will be even more pressed by financial crises within the sector.

**References**


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**Italy’s new fiscal federalism**

George France

In May 2009, Italy’s Parliament approved Law 42 which sets down the broad elements of the new fiscal federalism which the national government intends to introduce over the medium term. “Fiscal federalism” is concerned with the working of the arrangements used to govern the financial relations of different levels of government. Under the new fiscal federalism, sub-central governments will enjoy a substantial increase in financial autonomy with the aim of securing a closer match between their spending powers and their tax revenues. This will consist, in the main, of the national government ceding pre-specified guaranteed shares of the revenues raised within the territory of a region from national value added tax and national income tax. Law 42 also changes how the State’s contribution to each region’s spending needs in the health care sector is to be calculated.

**Funding and expenditure mismatch**

As devolution has proceeded over the years in Italy, a mismatch has emerged as sub-central governments acquired independence in administration and organisation at a faster rate than they did the authority to raise the financial resources to finance these. For example, on average own-revenue sources have provided 38% of total regional revenues, ranging from 56% for the richer northern regions to 26% for the poorer southern regions. This ‘skewness’ between spending and revenue powers has contributed to the creation of a problem of accountability and a record of intergovernmental strife. The process of devolution is most advanced in the public health care sector; 70% of the total regional budget goes on health care and the regions manage 90% of total public expenditure on health care. The sector has been characterised by chronic deficits, with the regions regularly spending more than the annual funding allocation they receive from the State.

This accountability problem was aggravated by a constitutional amendment in 2001 whereby the regions were required to guarantee to all residents a health care entitlement (specified in the form of positive and negative lists of services). The aim here is to protect the ‘national interest’ in health (defined in terms of universal, comprehensive and financially accessible care), which it is feared is threatened by the centrifugal forces set in motion by devolution. This entitlement is defined centrally in consultation with the regions, but it is the State which has to ensure that all the regions have the financial means necessary to deliver it.

The problem is that the regions, in the knowledge that the State is obliged to guarantee them funding for the entitlement, have had an incentive to spend more than may be strictly necessary or at least to be less than fully zealous in trying to live within their annual funding allocations: spendthrifts may have been rewarded at the expense of the more frugal.

All this has spurred the central government, faced with the constraint of meeting its obligations in respect of European Monetary Union regarding aggregate levels of public expenditure and public debt, to apply measures deliberately aimed at curtailing the autonomy of those regions revealed to be serial deficit spenders. For example, the central government has begun to require that regions with budgetary difficulties introduce new and/or increase patient copayments and regional taxes. This is causing anxiety about geographical equity.

Moreover, since such central intervention means in effect backtracking on the devolution design, at least for the regions involved, it could have political costs for the national government. The intention of Parliament now is that, being granted expanded tax revenue sources, the regions will be more inclined to live within their means and be more accountable for their actions to both their regional electorate and the national government.