Sources of Financing Health Care in Poland – Findings

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Abstract

In the presented article scientific works published within the grant project were used. The objective of the article is to present results of the scientific research conducted by an international community of financial law researchers. The basic objective of the scientific project implemented was to establish whether Polish legal regulations determining types of public sources of financing secure the implementation of tasks within health care. From the conducted research it can be concluded that the health insurance premium constitutes the main source of financing health care in Poland. Significant sources of financing health care include budgets of local government units and state budget.

Keywords

health protection; public finances

1 Introduction

Between 2015–2018, scientific research was conducted the subject of which involved legal issues of public sources of financing health care in Poland. The research was conducted within the scientific project entitled "Sources of financing health care in Poland – legal aspects" financed within the PRELUDIUM 8 competition organised by the National Science Center (project no. 2014/15/N/HS5/01735).

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In the presented article scientific works[2] published within the grant project were used. The objective of the article is to present results of the scientific research conducted by an international community of financial law researchers. The basic objective of the scientific project implemented was to establish whether Polish legal regulations determining types of public sources of financing secure the implementation of tasks within health care.

This article and other works developed within the scientific project were prepared most of all based on the dogmatic and legal method. For the implementation of objectives of the grant research project, legal regulations and financial law statements concerning legal and financial institutions related to public sources of financing health care were presented and examined. The dogmatic and legal method was completed with historical and legal methods and legal and comparative method, as it was necessary to establish the genesis of legal regulations concerning public sources of financing health care in the currently applicable form and their comparison with solutions functioning in other countries.

2 Catalogue of Sources of Financing Health Care in Poland

The principles of organisation and financing of health care in Poland are determined primarily by constitutional regulations. Pursuant to Art. 68 sec. 2 of the Constitution of the Republic of Poland (Constitution of the Republic of Poland of April 2, 1997, hereinafter: Constitution of the Republic of Poland) public authorities ensure equal access to healthcare services financed from public funds to citizens regardless of their financial situation. The conditions and scope of providing services are specified in the Act. From the provision referred to, it can be concluded that the basic source of financing health care should be public financial resources. In Art. 8 of the Constitution of the Republic of Poland, the legislator does not impose a specific model of organisation and financing of health protection in an unambiguous way. Establishing detailed principles in this scope was left to the legislator. Provisions of the Constitution of the Republic of Poland do not indicate any specific resources from which health care services will be financed (Lenio, 2018b: 62–63).

In relation to this the Polish health care system can be based among others on original assumptions of the Beveridge model or the Bismarck model. The legal bases for the organisation and financing of health care in Poland result primarily from the Act on health care services financed from public funds (The Act of August 27, 2004 on health care services financed from public funds, hereinafter: HCSA) and the Act on Medical Activity (The Act of April 15, 2011 on medical activity, hereinafter: MAA).

[2] They include among others: Lenio, 2018a; Lenio, 2018b; Lenio, 2018c; Lenio, 2018d; Lenio, 2017a; Lenio, 2017b; Lenio, 2017c, Miemiec and Lenio, 2017.

The catalogue of public sources of financing health care in Poland also includes: premiums for health insurance as a public levy, state budget expenditure and budgets of local government units (hereinafter: LGUs).

2.1 Historical and legal aspect

From the historical and legal analysis performed, it can be concluded that the method of financing health care in Poland, including sources of its financing, underwent significant transformations. In the interwar period health care was inextricably linked to sickness and maternity insurance. There was no separate source of financing health protection. Health services as well as services related to the occurrence of a sickness risk, which did not directly affect the provision of health care services, were financed from insurance premiums.

After World War II, there was a significant change in the method of financing health care. First of all, post-war health service was clearly separated from the social security system. It should be underlined that the separation of the health care system from social insurance has been functioning until now. The insurance model of health care was also abandoned. Expenditures for health care have been included in the state budget. The state budget was the main and the only source of financing tasks in the field of health protection. In spite of political changes in 1989, this lasted until the end of 1998 (Lenio, 2018a: 117–118).

2.2 The Polish health care system – principles of functioning

The Polish healthcare system is based on common health insurance. Within its framework the following entities function: the insured and other beneficiaries, the insurer and the service provider (Morzycka and Kowalska, 2012: 101). The function of the insurer and the payer is fulfilled by the National Health Fund, and the function of the service provider is fulfilled by entities carrying out medical activity. The Fund as the insurer guarantees provision of health services in case of a health risk, however it does not provide such services itself. Financing of health care services by the National Health Fund is implemented based on the agreement concluded between the Fund and the service provider. In the organisational structure of the health care model approved in Poland, activities of LGUs and government administration bodies are very significant.

The purpose of the functioning of compulsory health insurance is to ensure beneficiaries with guaranteed health services. The provision of Art. 2 sec. 1 of the HCSA indicates that only entities included in the directory of beneficiaries, including insured persons, have the right to use healthcare services financed from public funds under the terms set out in the Act. The catalogue of insured persons includes most of all employees, farmers, people receiving pension benefits, judges and prosecutors, persons

running business, as well as officers of uniformed services and unemployed people. In light of the catalogue of insurance titles resulting in the creation of an insurance obligation, it seems justified to state that the health insurance system covers almost all persons within its subjective scope who based on Art. 68 sec. 1 and 2 of the Constitution of the Republic of Poland are entitled to health protection.

2.3 Premium for health insurance as the main source of financing health care in Poland

In light of Art. 79 sec. 1 HCSA, for most insured groups the method of calculating the amount of the health premium involves multiplication of the basis of the premium established in compliance with the provisions of the HCSA by the statutory percentage indicator (rate). Hence, the basis of the health insurance premium and the rate significantly affect its value. For most insurance titles, the basis of the premium is basically the insured person's income resulting from their activity covered by the right title. For some insured groups, the basis of the health insurance premium arising from the right title will not depend on the income from business activities (e.g. in case of entrepreneurs).

The value of the health insurance premium basically arises from Art. 79 sec. 1 HCSA and it is currently 9% of its basis. This rate applies when calculating health insurance premiums for all insured persons, except for farmers and members of their households, referred to in Art. 80 sec. 1a HCSA (Lenio, 2017a: 70). In case of farmers and members of their households specified in this provision, the rate is 1 PLN per conversion hectare of agricultural land on the farm (Lenio, 2017c: 407).

The health insurance premium is an important public levy in the Polish legal order, revenues from which constitute the main source of financing health care. However, a further increase in expenditure on public tasks in the field of health protection requires the modification of the legal structure of the health insurance premium.

The legal structure of the health insurance premium demonstrates that it has all the required features allowing it to be included in the catalogue of public levies, referred to in Art. 217 of the Constitution of the Republic of Poland. From research conducted above, it can be concluded that the health care premium is a public levy constituting a public, common, general, non-returnable and compulsory cash benefit imposed on the basis of the provisions of the Act, with a payable and purposeful nature, allocated for the implementation of the state's constitutional tasks in the field of health protection implemented by the National Health Fund as part of the universal compulsory or voluntary health insurance (Lenio, 2018a: 326).

It is justified to state that the health insurance premium constitutes a *sui generis* public levy and it cannot be equated with other benefits of this kind, including taxes. Their common features only show that they belong to the category of public levies the catalogue of which is internally diverse. The comparison of the health insurance

premium and public levies other than taxes (social security contributions and fees along with additional payments) does not demonstrate similarities which could result in the treatment of the service in question as the designate of any of the above-mentioned levies. In addition to features generally common to all public levies, the aforementioned types are in some cases payable and purposeful. However, the purpose of such services and their functions are different.

2.4 The state budget and budgets of LGUs as a source of financing health care in Poland

Expenditure of the state budget allocated for the implementation of public tasks in the field of health care can be divided into at least four categories. The first one includes expenditures earmarked for establishing and running medical entities and financing activities of entities carrying out medical activities. The second one includes funds allocated for financing tasks of the State Medical Rescue. The third category includes expenditures earmarked for financing certain healthcare services. The fourth category includes expenses made to pay health insurance premiums for some insured persons. The provision of Art. 86 sec. 1 item 2–15 HCSA contains a catalogue of insured persons who do not have to pay the health insurance premium from their own funds. In the catalogue the legislator included among others soldiers undergoing basic military service, unemployed people who do not receive benefits or scholarship, as well as people who receive permanent assistance from social welfare (Lenio, 2018b: 66).

A significant source of financing health care includes budgets of local government units. Based on Art. 9a and 9b HCSA, LGUs' funds may finance guaranteed healthcare services only for residents of a given local government community. Furthermore, also activities of medical entities, for which they are the leading entity, are financed from local government budgets. Therefore, LGU budgets constitute a source of financing debts of health maintenance organisations, including the net loss generated by them. Using LGUs' funds, medical entities are established operating as capital companies. LGU bodies can also provide entities carrying out medical activity with public funds in the form of subsidies or on the basis of a contract in the manner and under the terms set out in the regulations of the MAA.

The fact of allowing for financing of guaranteed health services from local government budgets in combination with the obligation to cover expenses to implement previous tasks of LGUs in terms of health care, transfers some of the responsibility for the functioning of the system to local governments.

However, LGU bodies do not affect the principles of its organisation and financing. This leads to burdening local government budgets without increasing their own revenue at the same time, and it also does not guarantee uniform rules for the provision of health services, which raises doubts as to whether the regulations in force comply with the provisions of the Constitution of the Republic of Poland. Increasing the scope

of tasks of LGUs in terms of health care manifests that the legislator is looking for new solutions in terms of sources of financing health services which would decrease the scope of burdens of the state budget and finances of the National Health Fund. Transferring the responsibility for financing the health care system to LGUs shows that the legislator is aware of the incorrect formation of existing sources of its financing (Lenio, 2018a: 418).

Financing of health care services from the state budget and from local government budgets, as well as making expenditures from these budgets for health care tasks also justifies the thesis in the light of which the Polish system of financing health care is not fully an insurance model. It is only based on the insurance method of financing health care.

2.5 European funds as a source of financing health care in Poland

European funds are the only foreign source of financing health care in Poland, which is of a permanent nature. Their aim is not to guarantee the financial stability of the health care system. In principle, they are to support state actions in the implementation of public tasks in the field of health protection.

The funds disbursed under the regional operational programs come from the European Regional Fund and the European Social Fund. Tasks implemented under the Operational Program Knowledge Education Development 2014–2020 are financed primarily from the European Social Fund, and funds from the Operational Program Infrastructure and Environment 2014–2020 – from the European Regional Development Fund and the Cohesion Fund (Gwizda et al., 2014: 128, 143, 163).

The vast majority of resources coming from national and regional operational programs are to be distributed among beneficiaries who provide health services financed from public funds or intend to provide them after obtaining EU support. The majority of beneficiaries who can carry out projects financed from European funds are public entities. Most of all, European funds from the Operational Program Infrastructure and Environment for the implementation of investment projects are reserved for public entities. The only exception are medical entities that have been privatised.

The rules for the distribution of EU funds significantly strengthen the position of entities performing medical activities and providing services financed from public funds, including public entities. However, it should be pointed out that the purpose of financing projects in the field of health protection is not to increase competitiveness in this sector. The rationale for the allocation of European funds to the implementation of projects related to the provision of health services is to increase access to them and improve the quality of their implementation. The final recipients of EU funds allocated for health care are beneficiaries, and not entrepreneurs operating on free market principles (Lenio, 2018a: 450–451).

3 Sources of financing health care in Poland – comparative studies

European models of health protection operate on the basis of the principle of social solidarity. They provide every citizen with the opportunity to benefit from health care services, regardless of their financial situation.

As part of this scientific research, a comparison of Polish legal regulations in the field of sources of financing health care with the regulations operating in Germany, Italy, Great Britain and Sweden was carried out.

The analysis of the currently operating European models of health protection performed within the project also leads to the conclusion that in each of them there are at least two sources of financing of the system. The Italian insurance model is financed from local budgets with significant support from the central budget. The German health insurance includes premiums and funds from the central budget. In contrast, the English National Health Service, with revenues from the state budget, also participates in revenues from social security contributions. This means that based on experiences of EU countries, it can be concluded that one public resource is insufficient to ensure the functioning of the health care system. Additional sources to support its functioning are required.

The Polish and German system operate based on the insurance model of health protection (Bismarck model). Therefore, the legal structure of the catalogues of financing sources has much more similarities than differences. The main feature of the analysed systems is based on the principles of their financing from revenues from health insurance premiums paid.[3] A manifestation of its implementation is the statutory manner of determining the value of the insurance premium, where its basis is the most important element. As it has already been indicated, in most cases it depends on the payment capability of the insured member of the fund. "The subjective economic performance of individual members of the funds" (Hase, 2007: 32) is decisive. Statutory health insurance with the same insurance risk and uniform rules for receiving benefits is financed by them to a different degree. The above should also be referred to the Polish health care system which in light of Art. 65 item 1 HCSA is also based on the principle of social solidarity.

Another similarity between the Polish and German system of financing health care is taking public expenditures for health insurance from the central budget. First of all, in the Polish version of common health insurance at least four types of expenses, including a wide range of health services, can be financed from the state budget. Second of all, from the German federal budget a general federal subsidy in the amount of 14.5 billion Euros per year is allocated to the health care system. Since 2016, it has had a permanent nature and it does not depend on the costs incurred by entities functioning within the statutory insurance (Lenio, 2018b: 68–69).

[3] Differences and similarities (including *de lege ferenda* conclusions) in the Polish and German health insurance premium are presented in Lenio, 2017a.

In case of the Polish and Swedish health care systems, a similarity in the principles of its financing is taking financial expenditures from local government budgets. Such budgets in both countries have their own sources of revenue, most of all in the form of local taxes. In Sweden and Poland there are horizontal compensation mechanisms in terms of revenues of local government units. Funds from local government units are allocated by local governments to all tasks implemented by them. There is no legal obligation to allocate them to strictly specified goals. However, a different role of local government budgets in financing health care should be indicated. In the Swedish system they constitute the main source of financing public tasks in the field of health care.

In relation to the fact that Polish and Swedish health care systems are based on different organisation models, there are numerous differences between them. In the Polish system the National Health Fund is responsible for the organisation and financing of health services. As it has been previously established, in Sweden a health insurance premium has not been introduced, while it is the main source of financing of the Polish health care system. There is no separate public levy to finance health protection, from which revenues secure tasks of the state in this scope from the perspective of the needs of beneficiaries. In the Swedish health care system there is no strict relationship between public revenues and expenses allocated to its functioning. All revenues obtained by regions are allocated to all expenditures made in order to implement all tasks imposed on them, and not only financing health care. An important difference in the catalogue of Polish and Swedish sources of financing health care is the widespread functioning of out-of-pocket payments made by patients in connection with their use of statutory services in the Swedish system. The scope of out-of-pocket payments made by beneficiaries in the Polish health system is relatively narrow (Miemiec and Lenio, 2017: 185–186).

In the British literature on health care, it is stressed that the UK health care system based on the budget model is a highly effective manner of financing health care (Davies, 2013: 11). It is assumed that the use of financial resources derived from general taxes and constituting revenues of the state budget causes an increase in the control of government administration bodies over the expenditure effected in the system of the National Health Service. Moreover, this kind of financing of health care does not generate high administrative costs allocated to the operation of the health system. Therefore, the health care model based on the National Health Service allows negative effects of the deficit in individual sectors of economy to be avoided (Davies, 2013: 110). The analysis of the National Health Service in the United Kingdom also leads to the conclusion that the state budget is not a sufficient source of financing health protection from the point of view of the needs of citizens as beneficiaries. Although it is an essential source of financing, the NHS must also participate among others in revenues from social security contributions, which in Great Britain is institutionally and organisationally separated from the health care system (Lenio, 2017b: 64).

In turn, the Italian health care system is a budget model in which there is no public health insurance, and beneficiaries are not obliged to participate directly in the costs of

the health care system by paying insurance premiums. The current catalogue of financing sources of the National Health Service results from many years of transformations in the organisation and financing of the health care system in Italy. From the findings, it can be concluded that the Italian health care system does not have one source of financing. In order to secure the implementation of public tasks in this scope, it is necessary for several types of resources to exist.

The basic sources of financing the National Health Service in Italy are of a public nature. The model of financing is based on public funds from the state budget and budgets of particular regions. Revenues from fees charged to beneficiaries in connection with the provision of a specific type of health services are also significant. The resignation of the Italian legislator from the obligation to pay fees for the use of the public National Health Service could, however, lead to a significant decrease in the amount of revenues allocated for the implementation of the tasks imposed on it. Nearly 18% of all expenses made for the health care system come from fees incurred by patients. Should the obligation to pay fees be abolished, it would be necessary to increase the share of public funds in financing the Italian health care system from other sources (Lenio, 2018c: 79–80).

4 Conclusion

From the conducted research it can be concluded that the health insurance premium constitutes the main source of financing health care in Poland.[4] Health care services provided within common health insurance are financed from revenues from health insurance premiums. The goal of introducing compulsory health insurance was to separate the health care system and its finances from the state budget. Some budget revenues were transferred to a separate fund aimed at ensuring the financing of health care services.

The health insurance premium does not fully secure the needs of financing the system. It is mainly caused by its erroneous legal structure which, without legitimate grounds, favours certain social groups while at the same time burdening others. An erroneous formation of the structure of the health insurance premium is indicated most of all by the existence of different rules for calculating its value depending on being a member of a specific social or professional group. As a result of the findings, it is claimed that employees and beneficiaries are the most burdened professional groups in terms of the obligation to pay the health insurance premium. Its payers are obliged to pay the health insurance premium from all revenues obtained by their entities without the possibility to reduce the amount of the basis of the premium, as in case of pension and disability insurance. People engaged in agricultural activities (with the exception of special departments of agricultural production) are in the opposite situation. They are clearly privileged in comparison to other social groups. It results from the agricultural

[4] The summary developed based on Lenio, 2018a: 453–473.

system formed for many years, within which incurring the burden of public services did not depend on the results of activities carried out.

Consequences of poorly formed principles of establishing the value of the health insurance premium, differentiating the scope of bearing the insurance burden by people subject to compulsory health insurance do not only apply to such people. In this article, it was also found that revenues from the health insurance premium are not sufficient to ensure the proper functioning of the health care system by the National Health Fund. Such errors also significantly affect the manner and scope of financing tasks of the state and local governments in the sector of health care from public funds from the state budget and budgets of LGUs.

A diverse catalogue of public sources of financing health care does not materially cover the implementation of state tasks in this respect from the point of view of the needs of beneficiaries. From the findings it can be concluded that the normative structure of legal and financial institutions determining the shape and efficiency of public sources of financing health care in Poland, as well as some of the relationships between them have been shaped incorrectly and require changes. Funds from sources that constitute the subject of this research are insufficient to ensure the correct implementation of public tasks in the field of health protection. Changes made in the structure of sources of financing are only of an ad hoc nature and they do not significantly increase expenditures from public funds. This results in the need to engage private funds by beneficiaries to ensure health care at the proper level, despite the fact that the Constitution of the Republic of Poland guarantees access to health care services financed from public funds regardless of the financial situation of the beneficiaries.

The legislator takes excessive care of financial interests of the state budget which results in the lack of an appropriately high level of revenues of the National Health Fund in comparison to the costs of financing health care services, for the organisation of which it is responsible, and in partial transfer of the responsibility for the health care system to local government units.

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