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Reforms of the health care financing system in Poland introduced between 2016 and 2018

Reformy systemu finansowania ochrony zdrowia w Polsce w latach 2016–2018

Abstract. In this article, reforms of the principles of financing the Polish health care system introduced between 2016 and 2018 were studied and presented. For this purpose, the author was required to indicate the fundamental principles of the organization and financing of the health care model in Poland. Reasons for the introduction of reforms also were specified. Moreover, the nature and consequences of the introduced changes were determined. The introduced reforms were assessed, indicating that some of them do not have a systemic character. The author concluded that it is necessary to introduce further reforms to increase expenditures to finance health care in Poland and demonstrated their scope.

Keywords: health care; financing; reforms.

Streszczenie. W niniejszym artykule zbadano i przedstawiono reformy zasad finansowania polskiego systemu ochrony zdrowia w latach 2016–2018. W tym celu konieczne było również wskazanie na podstawowe zasady organizacji i finansowania modelu ochrony zdrowia w Polsce. Określono także przyczyny wprowadzania reform. Ustalono również, na czym polegały wprowadzany zmiany oraz jaki odniosły skutek. Dokonano oceny wprowadzonych reform wskazując, iż część z nich nie ma charakteru systemowego. Autor ustalił także, iż niezbędne jest wprowadzenie kolejnych reform w celu zwiększenia nakładów na finansowanie ochrony zdrowia w Polsce oraz wskazał ich zakres.

Słowa kluczowe: ochrona zdrowia; finansowanie; reformy.

1. Introduction

Modern health care systems in the European Union[1] are essentially based on two theoretical models. The first is the model of the national health service (Beveridge model), which is characterized by covering the system operation costs from public funds coming from the central budget or local government budgets. The second model, common in EU countries, is the Bismarck model, the essence of which is the functioning of health insurance based on revenues from premiums paid by insured persons. The possibility of the autonomous formation of the principles of financing health care systems results from the primary EU law. It does not interfere with internal legal regulations concerning the catalogue of sources to finance health care. Pursuant to art. 168(1) of the Treaty on the Functioning of the European Union[2], EU actions must be carried out in respect of the responsibilities of Member States to define their health policy as well as the organization and delivery of health services and medical care. The European Union also imposes an obligation to manage health services and medical care, and to divide the resources allocated to them (art. 168(7) sentence 2 TFEU).

Legal issues in financing health care systems in the European Union countries are of increasing social importance. This is a result of the growing public demand for public services in the field of health care. There-

1 Further referred to as “EU”.
2 [2012] OJ C 326/49, further also referred to as “TFEU”.

fore, EU countries undertake a number of actions aimed at optimizing the costs of health systems and increasing the amount of funds from sources of financing. Changes to the existing regulations introduced in the Polish health care system between 2016 and 2018 constitute an example of reforms of health care financing systems.

The objective of this article is to study and present the causes as well as the consequences of the legislative changes introduced in the principles of financing health care in Poland.

The article uses the dogmatic and legal method.

2. Principles of the organization and financing of the health care system in Poland

Pursuant to art. 68(2) of the Constitution of the Republic of Poland[3], public authorities ensure equal access to health care services financed from public funds to citizens regardless of their financial situation. The terms and conditions as well as the scope of the provision of such services are specified in the act. The provisions of the Constitution of the Republic of Poland do not determine the manner of financing health care in Poland. This issue was to be settled at the statutory level. It is therefore allowed to assume principles of financing based on the Bismarck or Beveridge model. The constitutionality of the introduced solutions is conditioned by ensuring equal access to health services financed from public funds. This means that public funds should be the main source of financing health care in Poland.

The currently functioning principles of financing the health care system result from its transformations, starting from the reactivation of Polish statehood in 1918 to the end of the 20th century. At the end of the 1990s, a health care system based on the insurance model was introduced in Poland, the financing basis of which was the income from payments of in-

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3 The Constitution of the Republic of Poland of April 2, 1997 (Dz.U. [Polish Journal of Laws] No 78, poz. [item] 483, with subsequent amendments), further referred to as the Constitution of the Republic of Poland.

surance premiums by or for employees: this meant a return to solutions functioning in the interwar period. The budgetary model for financing health care, operating in Poland for about 50 years, proved to be inefficient and unadjusted to the ongoing political, social, and economic changes. However, the system functioning currently does not fully reproduce the solutions in force during the interwar period.

The principles of the functioning and financing of health care in Poland result primarily from two acts. The first act is the act on health benefits financed from public funds[4]. Provisions of the AHCS regulate the subjective and objective scope of the Polish health insurance system[5]. They specify a closed catalogue of persons subject to health insurance as well as a catalogue of uninsured persons entitled to health care services provided within the system. It is underlined that the subjective scope of compulsory health insurance covers over 99.9% of citizens[6]. The provisions of the AHCS also determine the legal structure of health insurance premiums as the main source of financing health care in Poland. They also indicate the need to finance the health system from public funds from the state budget as well as from budgets of local government units[7].

The second basic legal act determining the principles of the organization and financing of health care in Poland is the act on medical activities[8]. It specifies the principles of carrying out medical activities as well as the establishing and functioning of non-entrepreneur medicinal entities. Moreover, it specifies the possibility of financing entities performing medical activities from the state budget and from local government budgets.

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4 The Act of 27 August 2004 on health care services financed from public funds (Dz.U. of 2017, poz. 1938 with subsequent amendments), further referred to as the AHCS.

5 The subjective scope results from art. 15 of the AHCS. Pursuant to the AHCS, beneficiaries have, on the terms set out in the AHCS, the right to health care services aimed at maintaining health, preventing diseases and injuries, early detection of diseases, treatment, care and prevention of disability and its limitation.

6 S. Poździoch, *Prawo zdrowia publicznego. Zarys problematyki*, Kraków 2004, p. 40.

7 Further referred to as “LGU”.

8 The Act of 15 April 2011 on medical activities (Dz.U. of 2017, poz. 160, with subsequent amendments); further referred to as “AMA”.

The main entity managing the Polish health care system is the National Health Fund[9], the state organizational unit with legal personality. Its obligations, which are listed in art. 97 AHCS, include most of all the management of public funds originating mainly from premiums paid by the insured, as well as subsidies granted from the state budget for the implementation of certain tasks in the field of health care. The Fund is also responsible for determining the quality and availability as well as for the analysis of the costs of health care services to the extent necessary for the proper conclusion of agreements for the provision of health care services, conducting tenders, negotiations and conclusion of agreements for the provision of health care services, as well as monitoring their implementation and settlement. The National Health Fund is also responsible for financing health services provided to people without insured status. Important functions are also fulfilled by government and local government administration authorities owing to the need to finance the health care system from the state budget and LGU budgets.

As mentioned before, health insurance premiums constitute the main source of financing health care in Poland. In the financial plan of the National Health Fund for 2018, income from health insurance premiums will be more than 79 billion PLN (approx. 18.5 million EUR)[10]. The health premium legal structure depends on the subjective scope of universal voluntary health insurance. Employees and people remaining in non-employee relationships (e.g. contractors) are subject to health insurance. Health insurance also covers persons conducting non-agricultural economic activity, pensioners, persons receiving certain types of social security benefits, farmers, and uniformed services officers (art. 66(1) AHCS)[11].

Insured persons are obliged to pay health insurance premiums. Pursuant to art. 79(1) AHCS, currently the premium amounts to 9% of remuneration. For the majority of insured persons, the assessment basis for the

9 Further also referred to as the „Fund”.
10 The annual financial plan of the National Health Fund for 2018, www.nfz.gov.pl (access on-line: 15.12.2018).
11 Health insurance, in principle, also includes family members of the listed entities.

premium amount is their income. This applies in particular to employees, contractors, and home-based workers. For some groups of insured persons, the basis of the health insurance premium was determined by indicating the benefits due to given persons for the performance of their business activity or having a specific legal status resulting from separate provisions[12]. In relation to some groups of insured persons, the method of calculating the premium base is not dependent on their income or any other benefit of a similar nature. In the case of entrepreneurs, the tax base is the amount of money declared, which cannot be lower than 75% of the average monthly remuneration in the enterprise sector in the fourth quarter of the previous year, including payments from profit[13].

The health insurance premium should be treated as a public contribution constituting a public, general, universal, non-returnable, and compulsory cash payment imposed on the basis of the provisions of the Act, of a pecuniary and purposeful nature[14].

Next to the health insurance premium, another public source of financing health care in Poland is the state budget. It is used to provide debt repayment of independent public health care facilities[15] for which the forming entities include the minister, the central government administration body, or the voivode representing the State Treasury[16]. Furthermore, health services provided to beneficiaries without the status of an insured

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12 The catalogue of these insured persons includes mainly persons receiving a pension or disability pension.

13 The presented principles for calculating health insurance premiums do not apply to farmers. The scope of their charges with health insurance premiums was regulated differently from other professional and social groups. In the case of the majority of farmers, the amount of the health insurance premium for each person subject to insurance is calculated as the product of the conversion hectares of the farm run and the rate expressed in terms of amounts. Pursuant to art. 80(1a) AHCS the amount of the monthly health insurance premium is PLN 1 per each conversion hectare of agricultural land in an agricultural farm.

14 P. Lenio, *Publicznoprawne źródła finansowania ochrony zdrowia w Polsce*, Warszawa 2018, p. 326.

15 Further also referred to as IPHCF.

16 These bodies are obliged to make expenditures to finance debt and to cover it on their own by IPHCF, unless they decide to liquidate a facility. The second type of expenditure in the event of debt of IPHCF is financing its obligations in the event of liquidation or transformation (art. 61 and 72 AMA).

person are paid for from the state budget in the form of targeted subsidies based on art. 97(8) AHCS. They are transferred to the account of the National Health Fund which is responsible for their provision. The targeted subsidy also finances highly specialized services, as well as services provided, among other provisions, on the basis of the provisions of the Act on Counteracting Drug Addiction[17] and the Act on Mental Health care[18].

From the state budget, subsidies are also granted to the National Health Fund to finance operations of the State Emergency Medical Service. The legal bases for financing emergency medical services in Poland result from Chapter VI of the State Emergency Medical Services Act[19] (art. 46-50). Pursuant to art. 46(1) SEMSA, tasks of emergency medical service teams, excluding air emergency medical service teams, are financed from the state budget from parts administered by individual voivodes[20].

LGU budgets must be mentioned as the third source of financing health care in Poland. From these financial resources, expenses in order to finance the debt in the event of a net loss and failure to cover it by IPHCF are incurred, unless an LGU decides to liquidate a given facility. Another type of expenses related to debts of IPHCF is financing their obligations in the case of liquidation or transformation (as in the case of facilities operating in the state sphere).

Expenditure allocated to health care tasks in the legal form of a targeted subsidy, principles of which result from art. 114 and 115 AMA and are based on the agreement referred to in art. 116(1) AMA, can be financed from local government budgets. Subsidies granted may be allocated to specific health care tasks performed by all entities conducting medical activity. The subsidy may be granted for, among others, the implementation of tasks in the field of health policy programmes, health pro-

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[17] The Act of 29 July 2005 on counteracting drug addiction (Dz.U. of 2016, poz. 224 with subsequent amendments).

[18] The Act of 19 August 1994 on mental health care (Dz.U. of 2016, poz. 546 with subsequent amendments).

[19] The Act of 8 September 2006 on the State Emergency Medical Service (Dz.U. of 2016, poz. 1868 with subsequent amendments); further referred to as SEMSA.

[20] Tasks of air emergency medical service teams are financed from the part of the state budget administered by the Minister of Health (art. 48(1) SEMSA).

grammes and health promotion, including the purchase of medical devices and equipment and the implementation of investments necessary to carry out these tasks, as well as renovation works other than the above-mentioned investments, including the purchase of medical devices and equipment.

3. Reasons for the reforms implemented in the health care financing system

Data published by the Organization for Economic Cooperation and Development (OECD) shows that in 2016 current expenditure on health care in comparison to other EU and European Economic Area countries was at a very low level. For example, in Germany, current expenditure on health care in 2016 was 11.33% of GDP, and in the UK 9.7% of GDP. This type of expenditure was also the lowest compared to the GDP in the Central European countries. Current expenditure on health care in 2016 in the Czech Republic and Slovakia amounted to 7.2% of GDP and 6.9% of GDP, respectively[21].

As has already been established, the Polish health care system is financed from public funds. Nonetheless, out-of-pocket payments have a significant share in health care expenditures. Data published by OCDE shows that in 2015 the share of private funds used by beneficiaries to receive a specific type of service was 23.2%. Comparing the expenditure level financed from private funds to their level in other EU countries, including Central European countries, it must be indicated that in Poland it is relatively high. For example, in Germany, the Czech Republic and Slovakia in the same year, the share of private funds in health care expenditure was 12.5%, 13.7% and 18.4%, respectively[22].

The data presented by the Supreme Chamber of Control shows that access to health care services financed from public funds constitutes an

[21] Data based on: http://stats.oecd.org/Index.aspx?DataSetCode=SHA (access on-line: 15.12.2018).

[22] Ibidem (access on-line: 15.12.2018).

important problem of the Polish health care system. For example, the waiting time for endoprostheses in December 2016 was 1,263 days[23].

The long waiting time for a service within the public insurance system means that beneficiaries use private medical care. Some of them, owing to the high costs of services, cannot cover them with private funds. Hence, the situation deepens the disproportions in access to health care services financed from public funds.

The level of expenditures allocated for the implementation of public tasks in the field of health care may indicate the lack of funding for the Polish health care system at a sufficiently high level. This results in the limitation of full access to health care services financed from public funds. This means that people who pay health insurance premiums cannot effectively demand provision of services within a short time in relation to a specific event covered by insurance protection.

Furthermore, in the Polish literature on the subject of health care, it is stated that organizational changes made after the political transformation in Poland and the transformation of the health care system after the late 90s of the twentieth century caused an increase in the negative public opinion about the introduced organizational changes and the availability of health services financed from public funds. This results in the need to use private health care[24].

Underfunding of the Polish health care system, as well as the lack of public satisfaction with access to health care services financed from public funds, causes the need for the legislator to look for optimal solutions for the legal structure of public sources of financing the health care system in Poland.

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[23] Supreme Chamber of Control (Department of Health), *Realizacja zadań Narodowego Funduszu Zdrowia w 2016 r. (Informacja o wynikach kontroli) – oczekiwanie na świadczenia w województwach*, www.nik.gov.pl (access on-line: 15.12.2018), p. 10.

[24] Z. Skrzypczak, M. Czech, *Ocena funkcjonowania systemu ochrony zdrowia finansowanego ze środków publicznych w świetle sondaży ankietowych i doniesień prasowych* [in:] K. Ryć, Z. Skrzypczak (ed.), *Ochrona zdrowia i gospodarka. Mechanizmy rynkowe a regulacje publiczne*, Warszawa 2008, p. 52–53.

4. Consequences of reforms implemented in the health care financing system in Poland

One of the significant reforms introduced in recent years in the Polish health care system was the introduction of the possibility of financing health care services directly from LGU budgets[25]. Until the act of June 10, 2016 on amending the act on medical activity and some other acts[26] entered into force, LGUs could not directly finance guaranteed health services[27]. Their organization and financing were exclusively reserved for the National Health Fund and the Minister of Health. From LGU budgets only expenses for health policy programmes could be incurred based on art. 48 sec. 1 and 3 AHCS. Pursuant to art. 5 item 29a AHCS, they constitute a set of planned and intended actions in the field of health care assessed as effective, safe and justified, allowing the assumed goals to be achieved within the specified timeframe, involving the detection and implementation of specific heath needs and the improvement of health of a determined group of beneficiaries.

In compliance with art. 9a AHCS, in order to fulfil the needs of a local government community in terms of health care, an LGU can finance guaranteed services for residents of a given community, taking into account in particular the regional map of health needs, priorities for the regional health policy and availability of health care services in the voivodeship. Pursuant to art. 9b sec. 1 and 2 AHCS, an LGU can finance guaranteed services based on an agreement entered into with a service provides selected based on tender proceedings, to which similar principles apply as in the case of entering into an agreement for the implementation of health prevention programmes[28].

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25 More on the subject: P. Lenio, *Budżet jednostki samorządu terytorialnego jako źródło finansowania gwarantowanych świadczeń opieki zdrowotnej* [in:] W. Miemiec (ed.), *Księga jubileuszowa ku czci profesor Krystyny Sawickiej. Gromadzenie i wydatkowanie środków publicznych. Zagadnienia prawnofinansowe*, Wrocław 2017, p. 363–374.

26 The Act of 10 June 2016 on amending the act on medical activity (Dz.U. poz. 960).

27 In the Polish health care system, the guaranteed service is a health service, material health service and accompanying service financed in whole or co-financed from public funds on the terms and in the scope specified in the Act (art. 5 item 34 and 35 AHCS).

28 Therefore, the provisions on public procurement do not apply.

LGU authorities are not always obliged to select a service provider through tender proceedings. The situation is different in the case of units which are forming entities for medical entities or the only or majority partners, or shareholders in a capital company that is a medical entity that provides guaranteed services to the extent corresponding to the subject of an agreement entered into.

Based on art. 9b(3) AHCS, such medical entities have priority in the provision of health services financed by LGUs. From the rationale to the government bill amending the provisions of AHCS it can be concluded that the purpose of introducing priority in the provision of guaranteed services on the basis of the clause contained in an agreement entered into with an LGU was the limitation of the generation of losses by medical entities for which an LGU is the forming entity or shareholder (stockholder)[29].

The introduction of the obligation to enter into an agreement for the provision of services with public entities may lead to their unauthorized preference in relation to private entities. This order may also give rise to doubts in terms of compliance with the principle of independence of LGUs expressed in art. 165(2) and 167 of the Constitution of the Republic of Poland. Providing additional income to local government health entities does not seem to be a sufficient reason to introduce an exception to the principle of the independence of LGUs. The author of the article believes that the correct solution from the point of view of compliance of the introduced regulation with the constitutionally protected principle of independence would be to allow LGUs to entrust the provision of guaranteed services to medical entities for which they are forming entities or in which they have at least 51% of shares (stock) in their share capital, rather than imposing an obligation in this aspect. Tasks in the scope of including the provision of guaranteed services, may be implemented by entities operating in the private sector, which is based on the provisions of the Act on medical activity.

Another doubt regarding the introduced reform concerns its compliance with the principle of equal access to health care services expressed in

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29 Rationale to the government bill amending the act on medical activity and some other acts (Sejm print of the Sejm of the 8th term of office No 652), p. 14–15.

art. 68(2) of the Republic of Poland[30]. Art. 68(2) of the Constitution of the Republic of Poland, referred to earlier, assumes the obligation to respect the principle of equal access to health care services which are financed from public funds. The legislator did not introduce a limitation in the catalogue of the sources of financing in art. 68(2) of the Constitution of the Republic of Poland. The organization of the provision of guaranteed services pursuant to art. 9a and 9b AHCS is financed from public funds. Such funds come from local government budgets. Hence, the principle of equal access also applies to the financing of services from LGU budgets.

In the Polish literature on health care law, it is assumed that pursuant to art. 68(2) of the Constitution of the Republic of Poland, it is allowed to distinguish between the legal the legal situation of citizens. It cannot be based on arbitrary and unjustified criteria, and lead to discrimination or preferential treatment of some groups[31]. Differentiation of the legal situation of citizens may result from the "[…] system of values, principles and constitutional standards, justifying diverse treatment of similar entities" assumed by the legislator[32].

The subjective scope of guaranteed services is clearly shown in art. 9a AHCS. They can be financed by LGUs to fulfil the needs of local government communities and be provided only to their residents. The catalogue of entities authorized to use health services financed based on art. 9a and 9b AHCS has been statutorily limited to a specific group of citizens. From the above, it can be concluded that the legislator – introducing the possibility of financing guaranteed services from LGU budgets – differentiated the financial situation of particular citizens. The affiliation of a given beneficiary to a specific local government community seals the possibility to use guaranteed services financed from LGU budgets. Therefore, from the findings presented above, it can be concluded that the only

30 A. Karczmarek, *Opinia prawna dotycząca rządowego projektu ustawy o zmianie ustawy o działalności leczniczej oraz niektórych innych ustaw (druk sejmowy nr 562)*, p. 8; www.sejm.gov.pl (access on-line: 7.12.2018).

31 D.E. Lach, *Zasada równego dostępu do świadczeń opieki zdrowotnej*, Warszawa 2011, p. 364.

32 Ibidem, p. 364.

criterion differentiating the legal situation of citizens in terms of access to health care services financed from public funds is their place of residence.

Such an approach is not justified by the system of values adopted by the legislator, more so in the constitutional principles or standards. The author believes that the place of residence of a citizen cannot decide about the scope of guaranteed services to which he or she is entitled. If the legislators see the need to increase the objective scope of guaranteed health care services in the quantitative aspect, they should do so within the universal health insurance.

The act on specific solutions ensuring the improvement of the quality and accessibility of healthcare services[33] should be mentioned as another attempt to reform the Polish health care system by increasing the amount of public funds spent on its functioning. Pursuant to its art. 3 the improvement of quality and accessibility of health care services was to be achieved by increasing the funds allocated for medical equipment and devices in 2017. These funds came directly from the state budget. They were intended for the financing of oncological and neonatological services, equipping preventive health care practices, as well as purchasing vehicles in which health services in the field of dental treatment may be provided.

Tasks, referred to in art. 3 of the act, were financed in the legal form of targeted subsidies granted by the Minister of Health and individual voivodes. Moreover, based on art. 6(1) of the act, voivodes granted subsidies to LGUs for the task involving running a school intended to equip a preventive health care practice in part concerning the terms of providing guaranteed services by a nurse or a school hygienist. The causes for the introduction of the possibility for additional financing resulted mainly from that fact that the technical condition of Polish health care infrastructure is assessed as insufficient. The changing epidemiological and demographic situation in the country requires the introduction of specific changes aimed at the optimization of the allocation of health care resources, involving most of all the adjustment of the diagnostic and thera-

[33] The Act of 15 September 2017 specific solutions ensuring the improvement of the quality and accessibility of health care services (Dz.U. poz. 1774).

peutic potential to the needs of society, new medical technologies and IT technologies which creates the need to provide investment funds on an ongoing basis[34].

At the same time, the act defines the impassable expenditure thresholds for the goals indicated therein. Pursuant to art. 8(1) of the act, the maximum limit of expenditure of the state budget, which is a financial effect of the provisions of the act entering into force in 2017, will be 281.8 million PLN in total, including part which is at the disposal of the Minister of Health – 147.8 million PLN, and part at the disposal of voivodes – 134 million PLN. However, it is justified to claim that the introduction of the additional financing of some public tasks from the state budget funds in the amounts defined above did not significantly contribute to the improvement of the financial situation of the Polish health care system. Therefore, it should be underlined that the implementation costs of the tasks implemented by the National Health Fund are circa 82 billion PLN[35].

The act of November 24, 2017 on amending the act on health care services financed from public funds[36] constitutes an important reform of the manner of establishing expenditure on financing health care from public funds. The act entered into force on January 1, 2018. Pursuant to its provisions, the minimum amount of public funds allocated to cover the costs of health care services in the scale of one financial year was introduced in the Polish legal and financial system. Pursuant to art. 131c(1) AHCS, financial resources in the amount not lower than 6% of gross domestic product are spent on financing health care annually. However, further in the provision it was stated that the indicated threshold will apply only from 2025. The legislator introduces a principle in accordance to which between 2018 and 2024 the minimum level of public health care

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34 Rationale for the government bill on specific solutions ensuring the improvement of the quality and accessibility to health care services (Sejm Print of the Sejm of the 8th term of office No 1820), p. 4, www.sejm.gov.pl (access on-line: 15.12.2018).

35 Annual financial plan of the National Health Fund for 2018, www.nfz.gov.pl; (access on-line: 15.12.2018).

36 The Act of 24 November 2017 amending the act on health care services financed from public funds (Dz.U. poz. 2434).

expenditure is to systematically increase from 4.67% of GDP in 2018 to 5.80% of GDP in 2024. The minimum thresholds apply only to expenses from the state budget and the National Health Fund costs. This means that in practice the real level of public funds spent on health care will be higher as the source of its financing also comes from LGU budgets.

The fundamental purpose of the reform was to fully implement the constitutional standards arising from art. 68 sec. 1 and 2 of the Constitution of the Republic of Poland which oblige public authorities to ensure citizens – regardless of their financial situation – with equal access to health care services finances from public funds by increasing the financing of health care services. According to the initiators of the project, a solution aimed at the execution of the constitutional provisions establishing the right to health care and expressing the principle of equal access to health care services is the introduction of the minimum amount of expenditure from public funds depending on the amount of gross domestic product[37].

The amount of public funds intended for health care differs significantly from the standards functioning in other OECD countries. This results in longer queues and a decrease in availability of health care services which was noticed by the initiators of the project[38]. The reform introduced on January 1, 2018 is the first attempt to significantly increase financial expenditure on health care services since the act on health care services financed from public funds.

5. Conclusions

To sum up, it seems justified to claim that some reforms introduced between 2016 and 2018 regarding the manner and sources of financing health care in Poland were not systemic. The introduction of the law on specific solutions ensuring the improvement of the quality and availability

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37 *Rationale for the government bill on specific solutions ensuring the improvement of the quality and accessibility to health care services*, Sejm Print of the Sejm of the 8th term of office No 976, p. 3, www.sejm.gov.pl (access on-line: 15.12.2018).

38 Ibidem, p. 4.

of health care services was not significant for the financial condition of the Polish health care system. For it should be underlined that the application of the provisions of the act resulted in an increase in expenditure on financing the health care sector by only 281.8 million PLN (less than 1 billion EUR). The above remark should also be referred to the introduction of the possibility of financing guaranteed health care services from local government budgets.

The introduction of art. 9a and 9b into the provisions of AHCS was aimed at transferring some responsibility for the proper functioning of the health care system and for ensuring the constitutional right to health care by the state to LGUs. The statutory extension of the catalogue of tasks of LGUs in terms of health care, even by elective tasks, gives grounds for burdening local governments with the responsibility for irregularities arising from the poorly formed system of financing health care services by central authorities. This results in additional expenses for local government budgets, without at the same time increasing their revenues.

Increasing the scope of tasks of LGUs in terms of health care services shows that the legislator is seeking new solutions in terms of sources of financing health care services which would decrease the scope of burdens for the state budget and finances of the National Health Fund. Transferring responsibility for financing the health care system to LGUs also shows that the legislator is aware of the poor formation of the previous sources of its financing. However, changes in the structure of the sources of financing health care services should have a systemic and not an *ad hoc* nature. Most of all, they should correspond to the requirements of the provisions of the Constitution of the Republic of Poland in this aspect.

The statutory assurance of a certain level of public funds allocated for this purpose from January 1, 2018, depending on the amount of gross domestic product, must be indicated as a positive aspect of changes in the principles of financing the Polish health care system. This aims at leading the level of financing of the Polish health care system from public funds to the standards in most OECD countries and the European Union.

Based on art. 1(4) of the act amending the act on health care services financed from public funds, the need to increase health care expenditure must be included annually in the draft budget act presented to the Sejm by the Council of Ministers. This means that in the catalogue of public sources of financing health care in Poland, funds from the state budget will gain significance. The central budget has not played an important role in financing public tasks in terms of health care so far.

The author of the article believes that the legal structure of the health insurance premium, the income from which obtained by the National Health Fund constitutes the main source of financing of the Polish health care system, requires necessary reforms. It has two fundamental defects. The first one is the assessment basis for farmers. In the light of art. 80 AHCS most people conducting agricultural activities pay the premium in the amount of 1 PLN per conversion hectare. Hence, its amount has a preferential nature and provides preference for a specific social group in an unjustified manner. Farmers pay the health insurance premium in an amount much lower than other social groups, including employees and contractors as well as pensioners.

Another defect of the health insurance premium structure is the manner of calculating its amount in the case of entrepreneurs (people running business activities). Their premium does not depend on the amount of income or revenues. This results in the situation that entrepreneurs achieving measurable benefits from their business activities are obliged to pay the health insurance premium in the same amount as entrepreneurs who do not gain any profits.

Changes in the principles of calculating the premium assessment basis for farmers and entrepreneurs, which involve conditioning the premium amount on profits from business activities, could significantly contribute to an increase in the income of the National Health Fund because of the health insurance premium. It would result in an increase of financial expenditure intended for the implementation of tasks of the state in the field of health care services financed from public funds.

However, the fact of making attempts to reform the Polish health care system should be assessed positively. Despite their defects, they show care on the part of the legislator to ensure the proper level of quality of health care services financed from public funds and to increase their availability to Polish citizens.

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