Health Policy 118 (2014) 153–158

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

Implementation of the 2011 Therapeutic Activity Act: Will commercialization improve the financial performance of Polish hospitals?☆

Anna Sagan*, Alicja Sobczak (PhD)

European Observatory on Health Systems and Policies, LSE Health and Social Care, United Kingdom

ARTICLE INFO

Article history:
Received 11 June 2014
Received in revised form
30 September 2014
Accepted 30 September 2014

Keywords:
Health care reform
Hospitals
Health sector debts
Commercialization
Poland

ABSTRACT

The Therapeutic Activity Act that came into force on 1 July 2011 was aimed at achieving a large-scale transformation of public hospitals into Commercial Code companies. The change of the legal form, from a public entity to a for-profit company, was expected to improve the poor economic efficiency of the public hospital sector. However, the mere change of the legal form does not guarantee a better financial performance of hospitals and thus the success of the Act. In many cases, deep internal changes are needed to achieve improvements in the financial performance of particular hospitals. In addition, a set of other measures at the national and regional levels, such as the mapping of health needs of the population, have to accompany the legal transformations in order to improve the efficiency of the hospital sector. The recent slowdown in the rate of the transformations is another factor that renders the success of the Act uncertain.

1. Introduction – historical background

The legal framework governing Polish health care institutions (public and non-public) has been reformed twice since the early 1990s. Between 1991 and 2011, the legal framework was prescribed by the 1991 Act on Health Care Units. According to this Act, all public health care units (known as ZOZs) could take one of three forms: (1) budgetary units or establishments, (2) autonomous public health care units (known as SPZOZs), or (3) scientific research units.

Until the late-1990s the vast majority of public hospitals operated as budgetary units financed from budgetary sources. They were run by the Ministry of Health (and some other ministries), medical academies, and the regional State administration (voivodeships). The legal form of the SPZOZ, introduced by the 1991 Act, was modeled after the British NHS trusts and was designed to enable the development of an "internal market" in health care. Unlike a budgetary unit, an SPZOZ had a legal personality and was obliged to cover all the costs of its activity from its revenues (coming mainly from public payers) and follow general accounting regulations. It also had a significant autonomy over its internal organization and decisions on hiring and remuneration of its personnel (see Table 1 for the key differences between a budgetary unit and an SPZOZ).

From the mid-1990s, a growing number of budgetary units had been transformed into SPZOZs [14]. Early transformations (around 100 public health care units between 1993 and 1997) had been initiated by the reform-oriented

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

* Corresponding author. Tel.: +44 2079556712.
E-mail addresses: A.Sagan@lse.ac.uk, anna_sagan@hotmail.com (A. Sagan).

http://dx.doi.org/10.1016/j.healthpol.2014.09.017

Table 1
Key differences between a budgetary unit and an SPZOZ.

		Budgetary entity	SPZOZ
What is the share of public ownership?		100%	100%
Does it have legal personality?		No	Yes
How are expenses/costs covered?		From budgetary sources	From own revenues (mainly from contracts with public payers)
Who has control over its financial operations?		Public owner (e.g. Ministry of Health, Medical Academies, Regional State Administration)	Director (periodical financial statements are approved by the public owner)
Who is ultimately liable for its financial obligations?		Public owner	Public owner (public owner must cover all debts in case of liquidation or transformation of the SPZOZ)
What are the main reasons for its indebtedness?	Internal	– Poor management (lack of financial incentives for improving efficiency; expectations that debts would be cleared or repaid by the State)	Poor management (financial incentives to improve efficiency oftentimes ignored as debts were periodically cleared or repaid by the State)
	External	– Insufficient public sources (insufficient budgets in relation to the level of infrastructure and activity) – Rigidity of budgetary rules governing the budgetary entities (money allocated in the budget to one expenditure category, e.g. wages, could not be used to finance another category, e.g. repairs) – Lack of regulations against excessive accumulation of debts – Strong pressure (from the local owners and communities) to develop infrastructure and increase salaries – High level of inflation	– Insufficient public sources (limits in the NHF contracts; delays in payments by the NHF; no or partial payments for "overprovision" of services by the NHF) – Systemic mistakes (e.g. undervaluation of some services contracted by the NHF) – Lack of regulations against excessive accumulation of debts – Insufficient financial control by public owners over financial decisions of the management – Strong pressure on developing infrastructure and increasing salaries (competition for public financing from non-public health care providers)

Source: Authors' own compilation
Note: There is no hard data on how many entities were indebted in a given year. Public statistics provide information on the total health care debt (there is no separate information on the size of public hospitals' debt). In addition, the ownership structure and the number of entities were changing continuously, which would make it difficult to estimate the size of public hospitals' debt.

regional authorities and hospital directors. They were connected with other organizational changes, such as division of ZOZs into separate SPZOZs,[1] restructuring of hospitals (e.g. changes in the number and structure of beds and personnel, development of IT systems), intensive training of their management and other personnel (e.g. in the principles of general accounting). The newly established SPZOZs were financed form voivodeships' health care budgets according to global budgets and contracting instead of funding based on budgetary rules.

The second "wave" of transformations that took place in 1997–1998 and affected the majority of hospitals was legally "imposed" by the introduction of universal health insurance in 1999. All budgetary units had to be transformed into SPZOZs in order to contract health care services with public payers (initially 17 sickness funds replaced in 2003 by the National Health Fund – the NHF). These transformations had to be done quickly, often with no or minor internal changes. Debts that had been generated prior to the transformations were cleared. In the same year (1999), a new administrative organization of the country was introduced: powiats (districts/counties) were introduced as the intermediate level of territorial self-government, between the gminas (municipalities), at the lowest level, and the voivodeships (regions). Powiat authorities (there are 314 powiats and 65 cities of powiat status) became the owners/funding bodies for the majority of public hospitals – 429 out of 739 in 2002 (with the remaining public hospitals owned by the voivodeships (231), medical universities (52), and others (mainly the Ministry of Health) (22) [9]). The number of voivodeships was reduced from 49 to 16. As a result, the ownership structure of public hospitals became more complex (introduction of a new level of ownership – powiat) and more fragmented. The number of non-public hospitals grew rapidly from 38 in 2000 to 160 in 2006 (40 of them were established in place of the liquidated SPZOZs) ([5], pp. 10–11).

Despite the transformations of budgetary units into SPZOZs, the public health care sector as a whole continued to accumulate debts at a growing pace (there is no hard data on how many entities were indebted in a given year; see note under Table 1). The indebtedness mainly concerned public hospitals ([18], p. 120) but the scale of their indebtedness varied greatly, with about 15% of hospitals accounting for 80% of the debts and with some generating

[1] ZOZs were introduced in 1973 as integrated health care institutions. A ZOZ was a huge budgetary unit composed of a general hospital, primary health care clinics, specialist ambulatory care units, long-term care units, etc., providing health care for a large population (approx. 100,000 people). During the transformation from a budgetary unit into a SPZOZ, hospitals were "freed" from the integrated structure: they were replaced by separate SPZOZs for different health care functions (e.g. separate SPZOZs would provide hospital care, primary care, ambulatory care, long-term care) and/or units providing ambulatory and long-term care would be privatized.