







“Soft budget constraints in Polish public healthcare entities”

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SOFT BUDGET CONSTRAINTS IN POLISH PUBLIC HEALTHCARE ENTITIES

Abstract

Although the theory of soft budget constraints is widely presented in the literature, little is known about the factors of soft budget constraints in public hospitals in Poland. This study is relevant because many Polish hospitals struggle with serious debt problems. The study aims to systematise the regulatory and legal provision of soft budget restrictions in the activities of healthcare institutions, particularly public hospitals in Poland, and to assess the impact of these restrictions on their further functioning. An analysis of hospitals' regulatory and legal activities shows the implementation of various soft budget restrictions. On November 20, 2019, Poland returned to the soft budget constraints, which functioned immediately after the introduction of reforms in the late 90s of the last century. As of 2021, out-of-pocket costs for treatment have decreased to 19.56%, but costs are gradually increasing and in 2020, according to the World Bank, they amounted to 71.89%. The provision of medical services mainly by public hospitals owned by local governments and scattered healthcare debt make it difficult to liquidate an inefficient public hospital in the event of its default. The study proves that the main reason for not eliminating the soft budgetary constraints of hospitals through their commercialization was the inconsistency of the carried out reform of commercialization of hospitals with the financial condition of local authorities.

Keywords

soft budget constraints, healthcare system, public hospitals, debt, commercialization

JEL Classification

H51, H60, H75

INTRODUCTION

A soft budget constraint affects economic rationality by reinforcing a party's expectation that one party to a commercial or social contract will intentionally, directly or indirectly, remedy the other's financial deficiencies (e.g., deficits or debt). Although soft budget constraints were initially perceived through the prism of socialistic economies, they are often found in public sector institutions that are generally not profit-oriented, also in countries with liberal market economies and developed ones (Kornai, 1986; Kornai et al., 2003; Wu & Lin, 2022; Bai & Wang, 2022; Litovtseva et al., 2022; Arespa & González-Alegre, 2023).

In 1989, the reform of the Polish healthcare system began. In particular, during 1995–2009, medical expenses in the country increased five times (from PLN 18.5 billion to PLN 99 billion), and the share of GDP on healthcare increased from 5.5% in 1995 to 7.4% in 2009. Although Polish healthcare spending has significantly improved in recent years, current healthcare expenditure per capita, PPP (current international USD), was lower than other developed countries from OECD. In the case of Poland, it was USD 2,528.51. Whereas, for example, Great Britain USD 6,133.60, Denmark USD 7,139.64 and the United States USD 11,702.41 (World Bank, 2023). The financial support of the Polish healthcare system is provided by the funds of the National Medical

Insurance Fund, which is 1/3 formed from citizens' contributions and 2/3 from state funds. Most of the country's citizens (98%) have mandatory health insurance, which guarantees medical care.

Starting in October 2017, a system of providing basic hospital services was introduced in Poland, popularly called the "hospital network." The general goals of the reform included improving the organization, structure, and access to services provided by hospitals and facilitating hospital management (Dubas-Jakobczyk et al., 2019).

Although soft budget constraints are well-recognized, their existence in public healthcare entities requires further research because the rapid growth of public expenditures on the healthcare system did not reduce the financial problems of Polish public healthcare entities.

1. LITERATURE REVIEW

The term "soft budget constraints" was first used by Kornai (1979) to denote the specific relationship between enterprises and state authorities in a centrally planned economy. Kornai (1979) argued that the nature of budget constraints determines the behavioral response of decision-makers. Following this approach, it can be assumed that in the case of the private sector, managers adjust the costs of the managed enterprise according to the financial returns they expect from the sale of products or any other interest in the assets held (Kornai, 1979, 1986; Putterman, 1993; Kornai et al., 2003).

A relaxation of the budget constraint occurs when the strict relationship between expenditures and revenues is reduced because another organization, usually the government, pays for the excess of expenditures over revenues (Dudzevičiūtė, 2023; Bublyk et al., 2023). Thus, the budget constraint ceases to constrain decision-makers behavior (Kornai, 1986). Selective aid to the enterprise will not lead to a soft budget constraint. Only permanent or effective assistance to unprofitable enterprises can provide hope for the continuation of such practices (Kornai, 1979).

Extensive literature in government and economics explains the cause of soft budget constraints through external factors such as the state and its political system (Kornai, 1979; Bardhan & Roemer, 1993; Putterman, 1993). The nature of the socialist state catalyzes wrong financial projects to avoid the risk of high unemployment (Bai & Wang, 2022). The main prerequisite for developing soft budget restrictions is the paternal-

istic attitude of the state toward the enterprises (Kornai, 1979). The different perceptiveness of soft budget constraints was proposed by Dewatripont and Maskin (1995), introducing a model to endogenise soft budget constraints. Managers offer ex-ante inefficient projects as long as they are efficient ex-post. Therefore, a centralised system starts many inefficient projects that should not have started (Bai & Wang, 2022). It may lead to waste and abuse (Dobrowolski, 2001; Babczuk, 2008). Therefore, soft budget constraints fit the contract's opportunism identified by Williamson (1993).

Although soft budget constraints initially concerned centrally-planned economies, especially those under reform, the phenomenon may occur in different economic and social environments, including local governments (Mitchell, 2000; Duggan, 2000; Moesen & van Cauwenberge, 2000; Tsaurai, 2023; Petruk et al., 2022). This is especially true for healthcare (Kireyeva et al., 2022; Sarihasan et al., 2022; Aldasem et al., 2022; Sharma & Kumar, 2023; Joshipura & Lamba, 2023).

One may find an explanation of soft budget constraints in public healthcare entities' activities through an analysis of Segal's (1998) work. Based on the assumptions, the healthcare monopoly of many public hospitals gives them an advantage in their relationship with the state: their bankruptcy would interrupt the whole healthcare system too much. Hence, the state prefers to subsidize their activities than closing them down. More than half of the Polish healthcare entities are owned by districts, and many have financial problems (Kachniarz, 2008). Therefore, Bolton and Scharfstein's (1996) findings are valid. The

dispersed financial issues make it challenging to avoid liquidating an inefficient healthcare system when its default occurs.

Concerning healthcare institutions, which are under the management of local authorities, the problem of soft budget restrictions can arise in different planes. It can appear in the relationship between the subject of healthcare and the local self-government body as the establishing and controlling body. In such a situation, the decision of the managers of the healthcare institution is influenced by their belief that the local government will support them financially. However, attempting to transfer the debt burden from the public healthcare institution to its founder may lead to financial difficulties for the local government. So local government and healthcare managers can expect help from the state government. This approach can be a cascade of support for financial failure.

It should be noted that for soft budget constraints to cause a recurrent and general threat of bankruptcy of public healthcare facilities managed by local governments, the belief in the inevitability of financial assistance from the state's founder must be shared by the public heads of healthcare institutions. The same applies to local authorities (Babczuk, 2008).

The evaluation of the local authority's and central government's propensity to offer support to the public hospitals, as well as the assessment of the central government's tendency to provide support to the local authority, is based on the analysis and evaluation of:

- 1) the existing legislation defining the role of the supporting entity in the situation of the supported entity's insolvency;
- 2) previous experiences supporting hospitals by local authorities or central government in crises.

Legislation defining the relationship between the hospital, the parent institution, and the central government, and between the local government and the central government, may:

- 1) impose obligations to rescue hospitals that are at risk of bankruptcy;

- 2) impose a ban on admissions to hospitals at risk of insolvency; or
- 3) contain no precise regulation (Babczuk, 2008).

The propensity to transfer public money to individual recipients depends mainly on the nature of a country's political and budgetary structures (Alesina & Perotti, 1994). The nature of the budgetary constraints of public hospitals and local authorities is determined by their experience of the support the central government offers (Babczuk, 2008).

Although the previous studies analyzed soft budget constraints in Polish public organisations (Babczuk, 2008; Kachniarz, 2008), they did not comprehensively examine the direction and dynamics of soft budget constraint occurrence in Polish public hospitals and other public healthcare entities. This study fills out this gap and analyses whether adopted laws influence the soft budget constraint occurrence in public healthcare entities. The study aims to resolve the following research question:

RQ1: Do the Polish laws strengthen the existence of soft budget constraints in public healthcare entities?

Laffont and Tirole (1993), Schmidt (1996), and Schmidt and Schnitzer (1993) perceive privatization as a commitment mechanism in a financial efficiency problem. One may argue that the commercialization of hospitals – transforming their legal form to municipal, commercial law companies – is a clear and universal form of doing business that allows for the preservation of public ownership of entities. It links ex-post unprofitable health activities with ex-ante efficiency.

Although Babczuk and Kachniarz (2012) and Przybyła et al. (2014) showed the scale of the commercialization of Polish hospitals, they did not comprehensively explain why the commercialization of Polish hospitals was limited. Therefore, based on all of the above, determining the direction and dynamics of the emergence of soft budget constraints in Polish public hospitals and other healthcare institutions and the financial effectiveness of the commercialization program remains an urgent issue.

Based on the literature review, it is necessary to systematise the regulatory and legal provision of soft budget restrictions in the activities of healthcare institutions, including public hospitals in Poland, and to assess the impact of these restrictions on their further functioning.

2. METHODS

The methodological basis is a set of methods and techniques of scientific knowledge. The study uses databases (Google Scholar, Scopus, and Web of Science) to choose and analyze the literature to resolve the research questions. Besides, a significant part of this analysis includes the analysis of Polish laws and regulations available on the webpage of the Polish Parliament.

A systematic approach was used as a general scientific method, which allowed for analyzing the justifications for bills publicly available on the webpage of the Polish Parliament from 1997 to 2022. Finally, this study uses data gathered from audit reports published by the Polish supreme audit institution and public organization responsible for oversight of local government in Poland.

The study also used analysis, synthesis, and generalization to determine the theoretical aspects of the direction and dynamics of soft budget constraints in Polish public hospitals and other public healthcare entities.

3. RESULTS AND DISCUSSION

3.1. Responsibility for the debt of hospitals in the light of the law

The analysis of the provisions of the law, justifications for changes to the law published by the Polish Parliament and the judgment of the Constitutional Tribunal (Kancelaria Sejmu, 1997, 2005, 2007, 2009, 2016, 2016a, 2017, 2019, 2021, 2022) showed the following.

The Law Amending the Healthcare Entities Act and some other Acts of June 20, 1997 (Journal of Laws No. 104, item 661) created a legal and organizational framework for public hospital oper-

ations in Poland. Although this law introduced the concept of a public healthcare entity, its legal form was imprecise, making it the subject of consideration in courts of various instances (including the Supreme Administrative Court and the Constitutional Tribunal) and being amended 53 times during 1991–2009. Until June 30, 2011, the Healthcare Entities Act of August 30, 1991 (Journal of Laws from 2007 No. 14, item 89 as subsequently amended) primarily regulated the financial activity of public healthcare entities (Articles 35(b) and (c) and Articles 50, 60 and 61). According to Article 35(b), a public healthcare entity, including a public hospital, independently covers costs related to its activities and obligations. Article 60(1) provided that a public hospital covered any of its liabilities. However, Article 61 of the Healthcare Entities Act of August 30, 1991, did not specify an institution for auditing the annual financial reports of public hospitals. It resulted in a lack of consequences for disapproving the yearly financial information provided. This loophole limited the owner's ability to oversee public hospitals.

Article 60(2) of the Healthcare Entities Act of August 30, 1991, excluded the financial responsibility of public hospitals. A public hospital with bad economic conditions could not be liquidated if other entities could not realize the hospital's tasks in a manner securing the uninterrupted provision of healthcare services to the public. In such a situation, the hospital's founding body was obliged to finance the public hospital's liabilities (Article 60(4) of the Healthcare Entities Act of August 30, 1991). Besides, any liabilities and receivables of the public hospital before its liquidation had to be transferred to its founding body (Article 60(6) of the Healthcare Entities Act of August 30, 1991). This provision guaranteed that the public hospitals' financial results did not affect the other hospitals' activities.

The Healthcare Entities Act of August 30, 1991, did not make a public hospital manager responsible for the hospital having a negative financial result. They were also absent from the Public Finance Act of June 30, 2005 (Journal of Laws No. 249 of 2005, item 2104 as subsequently amended) and the Public Finance Act of August 27, 2009 (Journal of Laws from 2022, item 1634). It is only Article 16(2) of the Act on Violations of Public

Finance Management Regime of December 17, 2004 (Journal of Laws from 2021, item 289) enables charging a public hospital's manager with liability for the manager's negligence or non-performance of duties which resulted in the public hospital's dire economic conditions.

Since July 1, 2011, the provisions of the Medical Service Law of April 15, 2011 (Journal of Laws from 2022, item 633) have regulated the operations of healthcare providers. Article 7 of this Law states that the Treasury (represented by the minister, a central governmental agency, or a province head), local authorities, and medical universities may continue operating public hospitals. Since July 1, 2011, the provisions of Articles 51-82 of the Medical Service Law of April 15, 2011, have regulated the financials of public hospitals and set forth the rules for their legal and organizational transformations. Article 52 of the Medical Service Law provides that a public hospital shall use its resources and proceeds to cover the expenditure related to its operations and liabilities. Article 59(1) of the Law mentioned above also obliges public hospitals to cover any negative financial result of their operations.

Additionally, sections (2) and (4) of Article 59 of the Law mentioned above enabled the organizational transformation of public hospitals with debts. It means that when a public hospital shows a net loss on operations in its annual financial statement for any fiscal year, the amount of such loss, as increased by the assets impairment loss for the same year, may be covered by the founding body. However, the loss coverage must occur within three months after the financial statement is audited and approved. If the loss is not covered, the founding body shall have 12 months to commence the procedure of either a legal and organizational transformation or a liquidation of a public hospital. Article 60(6) of the Law mentioned above states that the assets, liabilities, and receivables achieved by a public hospital before its liquidation shall become its founding body's assets, liabilities, and receivables. When a decision has been taken to transform a public hospital into a commercial company, before executing a transformation deed, the founding body calculates a debt ratio of such a public hospital. Article 70 of the Law mentioned above provides that the debt ratio shall be calcu-

lated as the proportion of long- and short-term liabilities, less short-term investments, to the total income, such as public hospital achieves. Where the debt ratio thus calculated exceeds 50%, the founding body shall have to take over the liabilities of the public hospital involved in the amount, ensuring that on the day of the transformation of this public hospital into a commercial company, the debt ratio of the such newly formed company does not exceed 50%. Where the debt ratio thus calculated is at most 50%, the founding body may take over the liabilities of the public hospital at its discretion. What does it mean? The law states that newly established medical service delivery can be significantly indebted from day one. Article 80(4) of the Medical Service Law states that the rights and obligations of the previously existing public hospital are moved into a newly established commercial company.

In 2016, changes were introduced to the Act on Medical Activity (Act of June 10, 2016, amending the Act on medicinal activity and certain other acts (Journal of Laws, item 960). Their main goal was to stop the commercialization of hospitals, leaving the founding body obligated to cover the debt. The provisions resulted from fears that the public sector may lose ownership of healthcare entities. It was written in the justification for the Act, "It is necessary to maintain the influence of the state on the functioning of healthcare entities so that everyone can be guaranteed the constitutional right to health protection" (Kancelaria Sejmu, 2016).

The next idea was linked with the so-called hospital network. The system of basic hospital security for healthcare services was introduced on October 1, 2017, by the Act of March 23, 2017, amending the Act on healthcare entities financed from public funds (Journal of Laws, item 844). However, the criteria of these systemic changes did not consider the units' potential. It did not introduce significant changes in the internal organization and the allocation of resources to optimise the treatment structure. As a result, the few private institutions that focused on selected specialist procedures were closed.

The last legal accent in shaping the health care system in Poland was the judgment of November 20, 2019, of the Constitutional Tribunal, which ruled that Art. 59 sec. 2, the Act on medical activity, is

inconsistent with the Constitution of the Republic of Poland (Kancelaria Sejmu, 2019). It means that no clear rules limit hospitals' indebtedness. So Poland has returned to soft budget constraints, which functioned just after the implementation of reforms in the late 90s last century.

3.2. The hospitals' liabilities and commercialization program

In 1994 and 1995, public hospitals and other healthcare entities received PLN 2 billion from the central budget to cover the due liabilities. Next, in 1997, the State Treasury financed the liabilities due from healthcare entities and paid PLN 1.7 billion. In 1998, the state paid PLN 8 billion and reduced liabilities due to public hospitals (Młodzianowska, 2006). The state's financial support to public healthcare entities during 1991–1998 amounted to PLN 11.7 billion (Najwyższa Izba Kontroli, 1999). At the end of 2022, there were 585 public hospitals in Poland, including 125 capital companies (with 100% public capital). Most public hospitals were run by districts (255, i.e., 44% of the total) and voivodeship self-governments (175, i.e., 31%). Hospitals run by cities with district rights accounted for 8% (46 hospitals), and communal hospitals for only 2% (13 units). Ninety-four hospitals (16%) have been transformed into commer-

cial companies. In the fourth quarter of 2003, the liabilities of public healthcare entities totaled PLN 7.5 billion. In the fourth quarter of 2003, the liabilities of public healthcare entities totaled PLN 7.5 billion. In the following years, it steadily increased and amounted to PLN 18.9 billion in 2020, while due liabilities amounted to PLN 2.1 billion. One of the most significant shares in generating and due liabilities had public hospitals established and supervised by districts (35% of total liabilities). The hospitals that belonged to regional local governments generated the same scale of liabilities (Ministerstwo Zdrowia, 2021, 2023).

Figure 1 shows that despite the slight increase in healthcare expenditures, out-of-pocket costs for treatment began to decrease significantly starting in 2018. The corresponding increase in domestic general government health expenditure explains this trend. Because since then, Poland has switched to the Beveridge system, which, unlike social health insurance (SHI), is financed from state revenues.

According to Art. 170 sec. 1 and 2 of the Public Finance Act of 2005, the total amount of debt of the district and other local government units at the end of the budget year may not exceed 60% of the revenue of this unit in a given budget year, and dur-

Source: The World Bank (2023a, 2023b, 2023c).

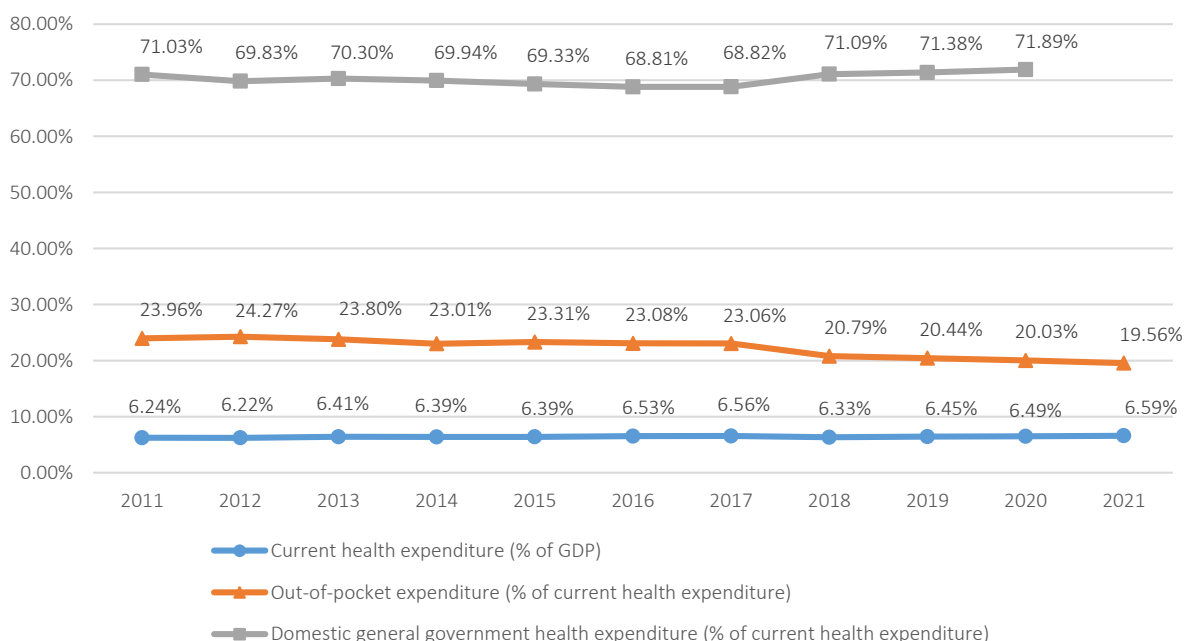


Figure 1. Health expenditures in Poland during 2011–2021

ing the budget year – 60% of the planned revenue at the end each quarter. In the following years, the so-called individual district debt ratio was implemented due to the amendment to the Public Finance Act (Article 243 of the 2009 Public Finance Act). This indicator further limited the possibility of self-government organisations getting into debt.

The total income of local government units in 2021 amounted to PLN 333.4 billion. Still, the income of districts was only PLN 36.1 billion, while over a third of all public hospitals belong to districts. The total due liabilities of local government units in 2021 amounted to PLN 57.3 billion. Districts' due liabilities at the end of 2021 amounted to PLN 2.1 billion (KRRIO, 2022).

One of the planned preventive measures against excessive indebtedness of public healthcare entities was their commercialization and, thus, the transformation of their legal and organizational form. It means that public hospitals financed by local governments were to be transformed into commercial law companies owned by local governments. Despite implementing this commercialization program, the scope of transformation turned out to be small. The pool of funds allocated for this purpose in the state budget was not used. As the Supreme Audit Office of Poland assessed in its report, in 2011–2014, local government units obtained subsidies according to the April 15, 2011 Act on medical activity, transforming only 45 public healthcare entities out of the planned 500. In the same period, only 23 were used, and 8% of the budget reserve was allocated for this purpose (Najwyższa Izba Kontroli, 2015).

The analysis of the legal provisions showed that loopholes in the existing legal system catalyzed soft budget constraints in hospitals. The study shows that the Polish regulations defined a hospital's founding body's role as primarily taking over the debt of public hospitals. However, a founding body could not review and enforce efficient public hospital management effectively. At the same time, the founding body remained fully liable for the financial result of such control. It was a significant obstacle to ensuring the proper operation of public hospitals. The significant obstacle also resulted from the insufficient regulation of public hospital managers' legal responsibility for the public hospitals' outcomes.

The comparison between legal changes and the financial situation of public hospitals revealed that any financial relief for public hospitals resulted in a sharp increase in new liabilities. It strengthened the “memory of the system” that balancing public healthcare entities is impossible, and the state must bear the responsibility for the debt. The classic example of a soft budget constraint that Kornai (1979, 1986) described for a socialist economy occurred in practice in the economy of a highly developed country – Poland.

The findings showed that more than a third of public hospitals are owned by districts, often needing help balancing budgets. This fact and many hospitals lead to the generalisation that, in a broader context, this study fits Bolton and Scharfstein (1996). It shows that the dispersed debt of Polish public hospitals makes it challenging to liquidate an inefficient healthcare system when default occurs.

It was only when the debt started to threaten the uncontrolled suspension of the functioning of many hospitals that efforts were made to regulate this problem systemically. Therefore, attempts were made to make financial aid conditional on creating a viable restructuring program for public healthcare entities, assuming the balancing of future operations. The hospitals' commercialization program – changing their legal form from public healthcare entities to commercial law companies – was an attempt to stop soft budget constraint existence. The program assumed a built-in mechanism limiting the debt to the size of its share capital. Exceeding it resulted in the obligation to declare such an entity bankrupt. The manager was also liable for acting to the detriment of the company. As noted earlier, despite the incentives, the commercialization of hospitals was small. This study shows that it is because districts primarily own public hospitals. The district authorities, the founding bodies of most hospitals, are subject to strict regulations on acceptable debt levels. Local governments in districts have no legal possibility to conduct business activity and generate revenues that could finance the commercialization of hospitals. Therefore, the commercialization of hospitals owned by districts could not be successful.

After the change of government in 2015, there was a retreat from the liberal direction of reforms.

First, the possibility of formal changes in commercializing hospitals was blocked. However, the responsibility of local governments for the debts of hospitals was left. It means significantly loosening the budgetary policy toward hospitals, resulting in a renewed debt dynamics increase.

While this study bears much kinship to that of Dewatripont and Maskin (1995), a difference ex-

ists. In this explanation, soft budget constraint in public healthcare entities is not due to the commitment of the state to reduce unemployment. Instead, the study shows the state's deliberate effort to maintain the healthcare system in local government and maintain a subsidized approach. It explains why public healthcare entities obtained financial support despite being economically ineffective.

CONCLUSION

The primary purpose of this study was to analyze the direction and dynamics of soft budget constraint occurrence in Polish public hospitals and other public healthcare entities. The paper assessed factors of soft budget constraint occurrence in public healthcare entities and complemented the existing soft budget constraint theory. Previous studies have shown, among others, that the state's role in creating soft budget constraints and subsidizing enterprises resulted from the desire to reduce unemployment. This study shows that the state makes soft budget constraints in the healthcare system, as local authorities own most hospitals. Maintaining the healthcare monopoly of many public hospitals gives them an advantage in their relationship with the state: their bankruptcy would interrupt the whole healthcare system. Besides, this study confirms previous findings and shows that dispersed debt holding makes it challenging to avoid liquidating an inefficient organization when default occurs.

Effective elimination of soft budget constraints in public hospitals is possible through their commercialization. However, when deciding to maintain the state's leading role in the healthcare system and maintain hospitals as capital companies, local government organizations must be financially prepared for this program. The commercialization program failed in Poland due to the mismatch between the implemented commercialization regulations and the local government's financial situation.

As with any research, this study also has some limitations. One is a timeframe. It needs to be longer to comprehensively evaluate the financial results of several hospitals operating as commercial companies. Therefore, subsequent analyses should include such hospitals after several years of operation.

AUTHOR CONTRIBUTIONS

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Writing – review & editing: Zbysław Dobrowolski.

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