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CHANGE OF THE ORGANISATIONAL AND LEGAL FORM OF INDEPENDENT PUBLIC HEALTHCARE CENTRES (SPZOSZ) AND CONSEQUENCES FOR FINANCING HEALTHCARE ENTITY ACTIVITIES

TOMASZ SKICA*, TOMASZ WOŁOWIEC**

Abstract

Local government units (LGU) are nowadays facing the very difficult and complicated task of making reasonable decisions regarding the transforming of SPZOs into capital companies. First, it seems necessary to carry out a simulation of costs and advantages of the assumed models and solutions together with an analysis of advantages and disadvantages of the new legal and organisational forms. The aim of this paper is to assess whether the process of transforming SPZOs into capital companies is purposeful and reasonable, and to define a way to prepare hospitals for functioning in an altered legislative environment. The paper draws attention to the fact that transformation itself does not guarantee that the results achieved by the given entity will automatically improve. The transformation can bring financial advantages for the newly created company and the local government, from the subsidies and remissions in accordance with art. 197 of the act on medical activity. Yet the conditions for getting such help are quite restrictive and not in every situation can financial help from the central budget be counted on. Such aid could help improve the financial standing of a hospital considerably. Also, it must be remembered that a hospital transformed into a capital company acquires the capacity to go bankrupt. If the new entity generates a loss, it may result in the owner having to raise the initial capital in order to avoid filing a bankruptcy petition by the company. In practice, the financial consequences for the local government are the same as in the case of having to cover losses. The difference lies in the continuity of the provided medical services.

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INTRODUCTION³

The issue of the model of financing the healthcare sector in Poland is a subject of endless discussion. The issues raised always include the questions of stabilising financial contributions, income sources' efficiency, or the adequacy of resources for expenses incurred by providers of medical services. Regardless of which issue is addressed, and from what point of view, the

discussion leads inevitably towards commercialising the health service sector, at least partially (See more on this in: Karkowski, 2010, p. 67). Thus a question arises about the scale of the problem, the sector's structure by entity, and the relation between the organisational and legal structure versus the shape and efficiency of the financial management of service providers (i.e. the supply side of the medical services market).

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³ The paper examines the healthcare sector in Poland based on statistical data for the end of 011. Thus at the comparison level, it presents the legal status shaped by the act of 30th August 1991 on healthcare centres (Dz. U. of Law of 2007, No. 14, item 89 as amended), in force until the end of June 2011. Yet analyses of the impact of the organisational and legal forms of public sector healthcare units in Poland and their changes on financial economy – taking statistics for the reporting year 2011 as the starting point – will be carried out on the basis of the current legal basis: the act of 15th April 2011 on medical activity (Dz. U. 2011, No. 112, item 654 as amended).

Considering the above problem, this paper aims to examine the impact of changing the organisational and legal form of independent public healthcare centres (SPZOZs) on financing their activity. The main topic of the planned discussion is thus to examine the advantages and costs which result from the greater financial autonomy of SPZOZs in the context of implementing their statutory objectives (Suchecka, 2008, p. 27). and the financial consequences of independent public healthcare centres transforming into capital companies.

As of 31st December 2011, there were 2 246 public ZOZs (healthcare centres) and 16 825 non-public healthcare centres functioning in Poland⁴. Adding to that the fact that there are almost three times fewer organisational sections of healthcare facilities functioning within public ZOZs in total, it may seem that non-public entities dominate in the structure of the national healthcare sector.

Yet the sector appears altogether different if we compare not the number but the size of ZOZs. The average number of organisational sections functioning within public healthcare centers in 2011 was 24 862, whereas for non-public ZOZs it was only 8 936. This situation is similar if healthcare facilities are compared with their size. In the case of the public sector, there was a smaller number of entities (5 521 public vs. 21 644 non-public) but they are superior in size. In the public sector, the average number of organisational sections per facility was 10114, whereas for non-public facilities it was only 6 947 (see table 1).

Table 1: Number of healthcare centres and organisational units and facilities included in them*

Public					Non-public				
ZOZ	ZOZ size	Facilities	Facility size	Sections	ZOZ	ZOZ size	Facilities	Facility size	Sections
2246	24 862	5521	10 114	55 839	16 825	8 936	21 644	6 947	150 351

* ZOZ size – average number of organisational sections within ZOZ. Facilities – healthcare facilities – ZOZ organisational units, e.g. hospitals, clinics, emergency services etc. Facility size – average number of organisational sections within a facility. Sections – organisational sections of healthcare facilities, e.g. clinic units, hospital wards, laboratories etc.

Source: Study based on <http://www.rejestrzoz.gov.pl/RZOZ/>

⁴ <http://www.rejestrzoz.gov.pl/RZOZ/raporty/raporty.do?rap=ilzozstrorg.html>. The definition of a healthcare centre corresponds with the definition indicated in art. 1, item 1 of the act on healthcare centres.

A comparison of public and private sector market shares in the health services market, based on the criterion of the total number of healthcare centres or of market saturation (i.e. the number of hospital beds per 10 thousand inhabitants), can be misleading. Nevertheless, analyses which consider the number of hospitals functioning within each sector remove any doubt. Among public healthcare centres functioning in Poland in 2011, 693 were public hospitals⁵, whereas the number of non-public hospitals was as high as 1 326, i.e. almost twice as the number of public service providers. The findings are clear. They prove that the national healthcare sector is evolving towards a model based on non-public provision of medical services financed by public payers⁶. Due to the fact that the financial management of public sector entities is less effective than in private entities rendering the same services, it seems reasonable to look for solutions which effectively combine the availability of medical services which is characteristic for the public sector with providing the services effectively (which is a domain of the private sector).

The described background shows that it is necessary to analyse the situation on two complementary levels. The first one will concern diagnosing the directions of current changes in the area of organisational and legal forms of public healthcare sector units as observed in 2006-2011 (inclusive). The period chosen for the analysis is justified by two circumstances. These are: the Act of 30th June 2005 on public finance⁷ (currently not binding) coming into effect, reorienting the public finance sector (PFS) towards its current shape according to the Act of 27th August 2009⁸ on public finance; and cessation of the Act of 30th August 1991 on healthcare centres⁹ abrogated with the Act of 15th April 2011 on medical activity¹⁰. The second level will concern the potential advantages and costs of transforming the units in organisational forms allowed by the Act on public finance of 2009 into commercial companies, and the subject of analysis will be both financial and non-financial aspects of the organisational and legal transformations.

⁵ For the purposes of this paper, entities within two generic categories covering: hospitals (HP.1) and inpatient centres of nursing and long-term care (HP.2), were classified as hospitals.

⁶ See <http://www.abc.com.pl/problem/710/7>.

⁷ Dz. U. of 2005, No. 249, item 2104 as amended.

⁸ Dz. U. of 2009, No. 157, item 1240 as amended.

⁹ Dz. U. of 2007, No. 14, item 89 as amended.

¹⁰ Dz. U. of 2011, No. 112, item 654 as amended.

ZOZ ORGANISATIONAL AND LEGAL FORMS AND THE FINANCIAL MANAGEMENT FORMULA

When analysing the organisational and legal forms of PFS units, in which public healthcare centres can be created and run, it is necessary to point out at the start that as the legal order was changed (i.e. when the Act on healthcare centres expired) the focus shifted, with respect to current regulations, towards commercial partnerships. The Act on healthcare centres stated in art. 35c item 1 that a public ZOZ can be run as a budgetary unit, a public sector enterprise or an independent public healthcare centre, whereas art. 6 of the Act on medical activities regulates the issue of forms allowed for medical entities totally differently. Firstly, a catalogue of the establishing entities has been redefined. In the Act on ZOZs, entities establishing public ZOZs according to the criterion of form which newly created units can take have not been diversified, while the Act on medical activity makes such a division¹¹. Furthermore, the Act on ZOZs, which expired 30th June 2011, named the following entities as competent to establish ZOZs: a minister or a central body of government administration, a voivod, an LGU (Karski, 2009, p. 39), a public medical university or public university which pursues educational and research activity in the area of medical sciences, and a Postgraduate Medical Education Centre. Now, according to the Act of 15th April 2011 on medical activity, the State Treasury (represented by a minister, central body of government administration, or voivod) and a local government unit (i.e. a commune, a district/powiat, a region/voivodship) can create and run a medical entity as a capital company, a budgetary unit, or a SPZOZ. The catalogue of establishing entities has been extended to include medical universities (cf. art. 7 of the Act), with the meaning of this term explained in art. 2, item 1, point 13 of the Act on medical activity. According to it, a medical university should be understood as “a public medical university or a public university pursuing educational and research activity in the area of medical sciences, or a Postgraduate Medical Education Centre”. The regulations state, however, that although a thus defined medical university can establish and run a medical entity, the possibility of choosing the form for such an entity is

¹¹ Cf. <http://www.lexagit.pl/informacje/kolejna-rewolucja-w-sluzbie-zdrowia/>.

limited to choosing solely between a capital company or a SPZOZ, excluding a budgetary unit (See more on this in: Sobiech, 1990, p. 169).

The reasons given above must be verified empirically. Shifting in the analysis towards statistical data, it is possible to define the potential of healthcare in Poland and trends of its changes. The first step

towards reaching such an aim is to verify the national potential of the healthcare sector. It is presented in table 2, both for public and non-public ZOZs. It is a starting point for analysing the structure of medical service providers functioning within the public sector, divided by the organisational and legal forms of their activity.

Table 2: Organisation and potential of healthcare* in Poland as of 31st December 2011**

Region	Public						Non-public					
	ZOZ	ZOZ size	Facilities	Facility size	Sections	Sections - saturation	ZOZ	ZOZ size	Facilities	Facility size	Sections	Sections - saturation
Łódzkie	159	32,044	500	10,190	5095	17.53	1170	12,902	1732	8,715	15095	51.92
Śląskie	213	24,826	400	13,220	5288	25.55	2478	8,710	2739	7,880	21583	104.30
Świętokrzyskie	110	20,836	284	8,070	2292	10.42	404	8,507	531	6,473	3437	15.63
Dolnośląskie	186	23,855	415	10,692	4437	43.98	1175	11,703	1669	8,239	13751	136.29
Kujawsko-pomorskie	139	19,806	273	10,084	2753	10.54	574	9,420	754	7,171	5407	20.69
Lubelskie	121	28,041	361	9,399	3393	10.50	944	8,293	1192	6,568	7829	24.22
Lubuskie	65	16,646	103	10,505	1082	2.11	480	5,842	678	4,136	2804	5.47
Małopolskie	175	24,143	462	9,145	4225	39.67	1308	7,489	1607	6,095	9795	91.97
Mazowieckie	317	33,104	1042	10,071	10494	49.88	2055	12,859	2693	9,813	26426	125.61
Opolskie	65	17,477	159	7,145	1136	9.40	389	6,578	493	5,191	2559	21.17
Podkarpackie	123	28,211	412	8,422	3470	15.92	870	6,597	1143	5,021	5739	26.33
Podlaskie	70	26,057	214	8,523	1824	3.85	649	5,020	750	4,344	3258	6.87
Pomorskie	137	18,847	218	11,844	2582	19.90	784	9,987	1048	7,471	7830	60.35
Warmińsko-mazurskie	116	15,845	199	9,236	1838	12.87	737	5,228	934	4,125	3853	26.98
Wielkopolskie	132	22,273	268	10,970	2940	8.77	1944	6,574	2579	4,955	12779	38.12
Zachodniopomorskie	118	25,339	211	14,171	2990	17.61	864	9,498	1102	7,446	8206	48.32
Total	2246	24,862	5521	10,114	55839	14.61	16825	8,936	21644	6,947	150351	39.33

* All organisational forms of ZOZ allowed by the Act on healthcare centres.

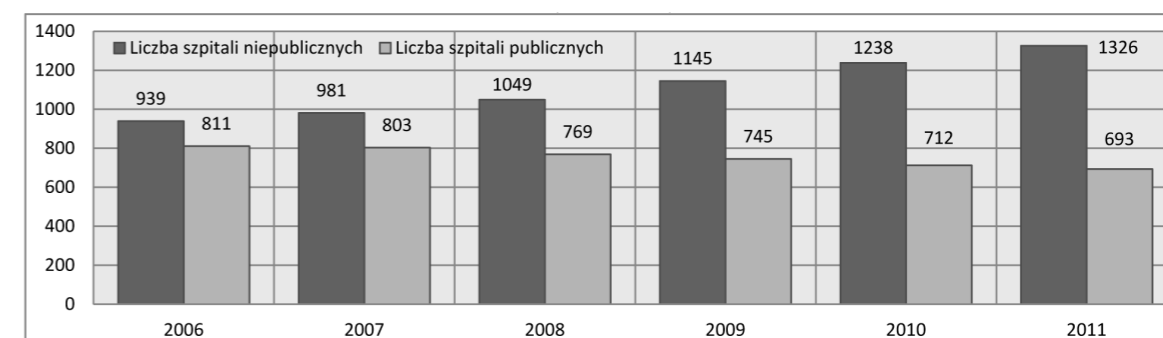
** Facilities – organisational units of healthcare centres, e.g. hospitals, clinics, emergency services, etc. Sections – organisational sections of healthcare centres, e.g. clinic units, hospital wards, laboratories etc. Sections – saturation – the number of sections per 10 thousand inhabitants. ZOZ size – the average number of organisational sections within a ZOZ. Facility size – the average number of organisational sections within a facility.

Source: Study based on <http://www.rejestrzoz.gov.pl/RZOZ/>

The statistics presented in table 2 show the diversity of healthcare potential in Poland, both territorially (i.e. by regions) and within each sector. The biggest number of public ZOZs in 2011 was found in the Mazowieckie region (317 units), and the smallest number in the Lubuskie region (65 units). Similar results were brought by analyses based on the criterion of the number of facilities per unit. In Mazowieckie, the number was 1 042, and in Lubuskie – 103. The biggest number of non-public ZOZs was found in the Śląskie region (2 478 units and 2 739 facilities), and the smallest in Opolskie (389 units and 493 facilities). In spite of such significant differences in the numbers of units functioning within each sector, the span

between the regions with the biggest and the smallest number of public and non-public healthcare centres was comparable, and amounted to 252 units for the public sector and 261 units for the private sector. The information presented so far discusses the structure of the healthcare sector in Poland in aggregate. Further in the article, only hospital facilities will be considered. For the needs of this paper, it has been assumed that these are entities listed in the statistics of two divisions: hospitals (HP.1) and inpatient centres of nursing and long-term care (HP.2). A comparison of the two is presented in diagram 1.

Diagram 1: Public and non-public hospitals¹² in Poland in the years 2006-2011 (inclusive)*



* All organisational forms of ZOZ allowed by the Act on healthcare centres.

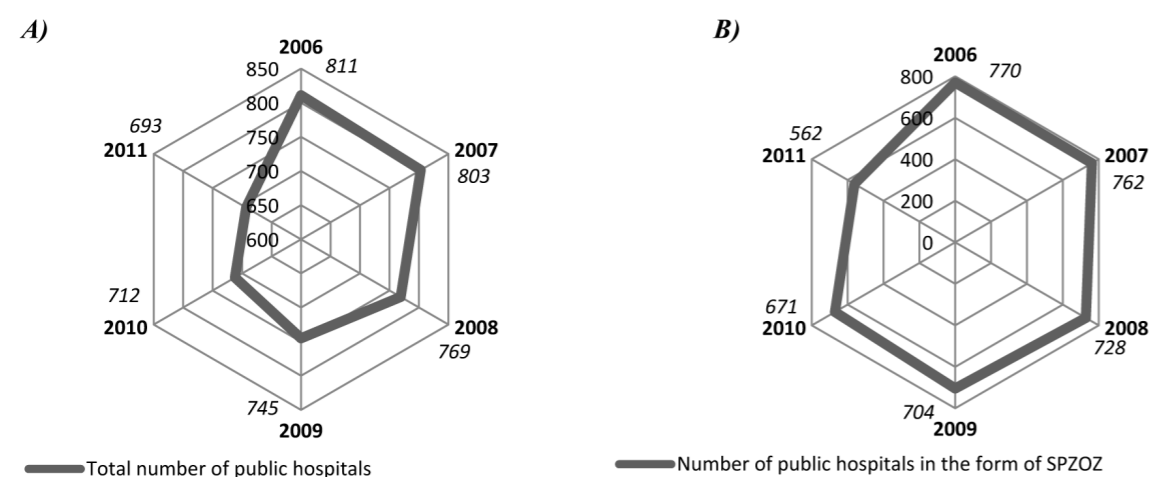
** Facilities – organisational units of healthcare centres, e.g. hospitals, clinics, emergency services, etc. Sections – organisational sections of healthcare centres, e.g. clinic units, hospital wards, laboratories etc. Sections – saturation – the number of sections per 10 thousand inhabitants. ZOZ size – the average number of organisational sections within a ZOZ. Facility size – the average number of organisational sections within a facility.

Source: Study based on <http://www.rejestrzoz.gov.pl/RZOZ/>

¹² Founding bodies of non-public hospitals established in the analysed period were: churches and religious associations, employers, foundations, trade unions, professional self-government and associations, natural persons, private, registered, limited and professional partnerships, private unlimited with share capital, limited liability and joint stock companies, as well as cooperatives. Cf. <http://www.rejestrzoz.gov.pl/RZOZ/>.

The above graphic illustration shows the number of public and non-public hospitals in Poland in the years 2006-2011 (inclusive). The comparison also exposes the trend of changes in the structure of healthcare in Poland, in the part represented by hospitals. The diagram proves that the drop in the number of public hospitals is accompanied by a growing number of non-public entities¹³. Analysing the dynamic of changes presented in the diagram, it is possible to define the power of progressing transformation in the structure of medical service providers. Only in 2006-2011, the number of public hospitals in Poland decreased by 118 units, whereas the number of non-public hospitals increased by as many as 387 entities. Thus the rate of public hospitals being replaced by non-public entities in the whole examined period was as much as 3.3.

Diagram 2: Public hospitals in total (diagram A) and independent public healthcare centres (diagram B)



Data from the following divisions were adopted for calculations: hospitals (HP.1) and inpatient centres of nursing and long-term care (HP.2).

Source: <http://www.rejestrzoz.gov.pl/RZOZ/>

¹³ Cf. http://wyborcza.pl/1,76842,9659923,Juz_1099_niepublicznych_szpitali_w_Polsce.html.

¹⁴ <http://www.rejestrzoz.gov.pl/RZOZ/>.

Basing on statistics conducted by the ZOZ register¹⁴, it is also possible to verify the next objective of this paper, i.e. answer the question of the dominant organisational and legal form in the structure of public hospitals. The graphic representation shown below proves that entities in the form of an SPZOZ dominate in the structure of public hospitals (cf. diagram 2). Therefore the other legally permitted organisational and legal forms in the healthcare sector (such as e.g. budgetary units) apply chiefly to the other (non-hospital) medical service providers functioning mainly in the open healthcare system.

Taking the above into consideration, it must be pointed out that the analysed source data show that the number of hospitals functioning as budgetary units has not changed since 2006 (i.e. the first year of the examined period). As of 31st December 2011, 24 entities conducted their activity in that form. At the same time there were as many as 680 ZOZs functioning as budgetary units in the whole health sector in Poland in 2011. This proves correct the above presented opinion that this organisational form is more adequate for open healthcare than for closed. Finally, it should be stated here that in the examined period there was only one hospital functioning as a budgetary unit in Poland (namely in the Lubuskie region). This individual case allows one to marginalise the significance of that organisational and legal form of PFS (as in the case of budgetary units) as appropriate for running public hospitals. As a result, in the discussion on the organisational and legal form in which a vast majority of public hospitals are run, financial management resulting from the form, and also on transforming public hospitals into commercial companies, is focussed on SPZOZs.

SPZOZ IN THE STRUCTURE OF MEDICAL SERVICE PROVIDERS

Taking into account the above findings, and at the same time creating the basis for analysing the impact of changes in the healthcare sector structure on the shape of hospital financial management, it is necessary to focus on the specificity of SPZOZs as medical service providers. Such a solution provides a way to verify the consequences of transforming the units into commercial companies in both legal and financial terms. Firstly, it should be stated that an independent public healthcare centre, in contrast to budgetary units and budgetary entities (nowadays run only by local governments), has a legal personality. It covers the costs of its own activity from its own resources and the generated revenues, and also settles other liabilities. An SPZOZ decides on the distribution of profit and covers losses, subject to article 59, items 2 and 4 of the Act on medical activity¹⁵. Thus it is

¹⁵ Art. 59 item 2: The establishing entity of an SPZOZ may within 3 months of the deadline for SPZOZ financial statement approval cover the centre's losses for the financial year, if the said financial result is negative (loss) after adding depreciation costs – up to the value of the loss. Art. 59 item 4: Unless the losses are covered as indicated in item 2, within 12 months of the time specified in item 2 the establishing entity issues a regulation, an order, or passes a resolution on changing the SPZOZ's organizational

exactly the opposite of entities operating as budgetary units. Here it is essential to indicate financing sources which determine public funds management. A hospital functioning as an SPZOZ obtains resources from chargeable medical activity, separate business activity (other than medicinal), donations, bequests, inheritance and public donations, including those from abroad (See more on the topic in: Golinowska, 2004, p. 52 and also in: Golinowska, 2006, p. 60). Moreover, an SPZOZ can receive public funds allocated for:

- 1) performing tasks within health policy programmes and health promotion,
- 2) renovation,
- 3) conducting projects financed with resources from the EU budget or non-refundable resources from aid granted by member countries of the European Free Trade Association (EFTA), or resources other than those listed above and coming from non-refundable foreign sources,
- 4) purposes defined in separate regulations and international contracts,
- 5) implementation of long-term programmes,
- 6) covering costs of educating and raising qualifications of people who practice medical professions¹⁶.

In comparison to other organisational forms in the healthcare sector, SPZOZ therefore means financial independence proved e.g. by the possessed assets (the founding capital and company capital), being a carrier of rights and obligations on the basis of civil law resulting from having legal personality, and financial management closer to that of a market economy. The founding capital of an SPZOZ is the value of the part of the property of the State Treasury, an LGU, or a medical university, allocated for the independent public healthcare centre. The company capital is the value of the SPZOZ property excluding the founding capital. In accordance with art. 57 of the Act on medical activity, the company capital of an SPZOZ is increased by net profit, the increased amounts of fixed assets' value resulting from statutory revaluation of the assets, and the amount of money transferred to cover losses. The SPZOZ fund is

and legal form or liquidating it. The above content is supplemented by art. 61 of the Act on medical activity. According to it, liabilities and receivables of an independent public healthcare centre after its liquidation become liabilities and receivables of the State Treasury, of a medical university, or of the competent local government unit. The regulation from the first sentence shall apply adequately to property.

¹⁶ Cf. art. 114 of the Act on medical activity.

decreased by net loss and the reduced amounts of fixed asset value resulting from statutory revaluation of the assets.

Discounting the content presented above, reference should be made to the possibility to transform a SPZOK into a capital company, as provided for by the Act on medical activity, and the conditions of the procedure. It is significant insofar that in the previous legal order there were no regulations directly concerning SPZOK transformations. As a result, both the Act and its regulations constitute a kind of novum in the organisational sphere of healthcare sector functioning in Poland. In view of the above, it is necessary to refer to the three statutory aspects in which it is necessary to consider the transformations mentioned. The first one concerns transforming an SPZOK into a capital company on the principles under art. 70-82 of the Act on medical activity. The second aspect (under art. 73 of the Act on medical activity) provides for converting several independent public healthcare centres into one company, provided that the transformed centres have the same establishing entity¹⁷. Eventually, the third aspect of SPZOK transformations regulated by the Act concerns the possibility of integrating SPZOKs (cf. art. 66 of the Act)¹⁸.

As proved by the interpretation of statutory provisions, the law provides numerous possibilities for modifying the existing structures of the healthcare sector. What is more, it leaves the decision on conversion to establishing entities, introducing the characteristic free-market liberalisation of solutions. Thereby focus within the organizational forms of medical service providers shifted even more towards establishing entities, thus triggering the possibility of pro-effectively shaping the sector's structures.

¹⁷ In art. 73, item 2, the Act on medical activity allows for an exception to the rule, stating that a transformation can consist also in transforming independent public healthcare centres which have different establishing entities but which are an LGU into one company. In such a case, the establishing entities, which are LGUs, conclude a relevant contract on the basis of resolution of the units' legislative bodies, to which contract they enclose a draft of the articles of association (statute) and a draft of the organisational regulations.

¹⁸ SPZOKs can be merged in two ways. The first one consists in transferring all property of at least one SPZOK (the acquired one) onto another SPZOK (the acquiring one). In the second version, a new independent public healthcare centre is created, formed of at least two merging SPZOKs.

CHARGEABLE LIABILITIES OF HOSPITALS AS STIMULI FOR DECIDING ON SPZOK CONVERSION

Debt of the healthcare sector in Poland is an integral element of its characteristics. A particularly high level of liabilities of healthcare centres was noted in 2004-2006. Reduction of chargeable liabilities resulted from public hospital debt cancellation under the Act of 15th April 2005 on public aid and restructuring of public healthcare centres¹⁹. The restructuring consisted mainly in debt rollover, that is making chargeable liabilities non-chargeable. Forecasts for the period up to 2012 (inclusive) predict a further increase of the debt of healthcare units from 12 524 million zlotys in 2011 to 12 808 million zlotys in 2012. At the same time, the growing debt is accompanied by progressive deterioration of liquidity of the healthcare sector (Grześkiewicz, 2011, p. 87). This situation coincides with the above mentioned act on medical activity, which regulates the possibility of converting SPZOKs into capital companies, coming into force. The fact is doubly important. Firstly, the Act gives a "possibility", not an obligation to transform independent public ZOKs into companies, thus maintaining the principle of autonomy of local government units as stated in art. 16 of the Constitution of the Republic of Poland²⁰. Secondly, transforming an SPZOK into a capital company does not require its prior liquidation, and thereby, its obligations are assumed by an establishing entity (e.g. a local government unit), without any prejudice to the provisions of art. 71 of the Act on medical activity²¹.

Here it is worth indicating the difference between private hospitals and non-public hospitals set up by units of the public finance sector, which include among others local governments. Shares of the former hospitals belong mainly to private investors, and in the case of local government hospitals, the majority

¹⁹ Dz. U. of 2005, No. 78, item 684 as amended.

²⁰ Dz. U. of 1997, No. 78, item 483.

²¹ Debt ratio is set as the relation of the sums of long-term and short-term liabilities reduced by short-term investments of an SPZOK to the amount of its income. In art. 72 of the quoted Act it is pointed out, however, that in a situation when the value of the debt ratio exceeds 0.5 - on the day preceding the day of transformation, the establishing entity takes over SPZOK liabilities of such value that the debt ratio determined on the day of transformation for the company resulting from transforming the SPZOK amounts to no more than 0.5. If the value of the debt ratio is 0.5 or less on the day preceding the day of transformation, the establishing entity may take over the SPZOK liabilities. The first liabilities to be taken over are the most overdue ones, including principal and interest.

shareholder is still most often an entity of the public finance sector, i.e. an LGU. That is why it is an LGU that makes the decision to convert an SPZOK into a non-public local government hospital. Yet bearing in mind that some local governments declare themselves sceptical towards the issue of converting hospitals into commercial companies, the neutral nature of the provisions of the Act on medical activities seems to perfectly fit into the undeclared environment of local governments, leaving the decision on the potential transformation to the parties concerned, i.e. the establishing entities. At the same time, it ought to be noted that the LGUs which have made the transformation emphasize that thanks to the move they have gained hospitals not encumbered with any debts, obliged to pursue a restrictive financial policy, and the costs of its operation are up to 30% lower than in public hospitals²². Paradoxically, the indicated decision-making problem concerning optional transformations of SPZOKs into companies may be solved by provisions of the above quoted Act on medical activity. Its regulations state that when an SPZOK is transformed into a capital company by the establishing entity (according to principles indicated in art. 69-82 of the Act) by 31st December 2013, some liabilities (primarily those that are public or legal) taken over from the SPZOK by the establishing entity will be remitted (cf. art. 190-193 of the Act on medical activity). The establishing entity (e.g. a local government unit) which converted the SPZOK into a capital company may by 31st December 2013, based of art.196 of the above quoted Act, apply for a special-purpose subsidy from the state budget. It should be clearly emphasized here that, due to the generally poor financial condition of SPZOKs, this argument can catalyse initiatives to convert public SPZOKs into companies. Regardless of the statutory "arguments" the reasons which objectively justify transforming hospitals into companies are economic factors, including:

- 1) a unit's debt and/or loss of liquidity,
- 2) "rescuing" the local government from a debt limit resulting from the Act on public finance (obligations of a liquidated SPZOK become in consequence the local government's debts),

²² D. Sikora, Niepubliczne szpitale także leczą bezpłatnie (Non-Public Hospitals Also Treat for Free), Retrieved from: <http://praca.gazetaprawna.pl/artykuly/5375>.

- 3) rational separation of hospital and local government budgets which stimulates effective financial management,
- 4) the need to restructure SPZOK personnel, flatten organisational structures and effectively delegate power to competent staff,
- 5) implementing modern management methods based on market criteria and pro-quality and efficiency criteria,
- 6) acquiring an investor and/or investing in medical equipment and apparatus,
- 7) "lending credence" to a hospital for external entities, such as banks, contractors, lease and factoring companies, etc.

Changing the organisational form of a hospital brings not only advantages. To be objective in the analysis, it should be noted that a company's formula is also fraught with certain defects. Therefore the decision on conversion should be made on the basis of a balance of benefits and costs made for each SPZOK separately. The worst possible scenario is universalising activities only due to relationships in the surrounding environment and yielding to the "psychology of the majority".

Among the consequences (both positive and negative) of transforming a hospital into a company, the following categories of consequences are listed:

- 1) a commercial company "may not" get into debt in an unreasonable way,
- 2) the board of directors and the supervisory board have financial and criminal liability for improper management,
- 3) a commercial company with assets obtains creditworthiness and credibility in banks and other financial institutions,
- 4) the company, still owned by a local government, becomes independent from its budget,
- 5) a credit incurred by the hospital is not directly charged upon a local government's budget,
- 6) the company may conduct commercial activities that are an additional source of income,
- 7) the company can start new activities regardless of the payer (i.e. contracting services through the National Health Fund),
- 8) a commercial company may be capitalised by new shareholders,
- 9) capitalising a company creates possibilities to build and modernise the infrastructure, provide new equipment and apparatus, or implement new technologies,
- 10) it is possible for an SPZOK to declare bankruptcy,

11) if EU funds are used, the local government must keep 100% of the shares.

The presented circumstances constitute a balance of the benefits and costs of making a decision on converting an SPZOZ into a company. They prove that the decision should be made after first considering the consequences of the planned transformations. The mere fact of conversion cannot be treated as a panacea for problems of the healthcare sector in Poland. It is only about a new hand in the sector. The real effects of changing the organisational form of hospitals will still be decided on by managers of medical entities together with decision-makers who create the financial conditions of the healthcare sector. In view of the above, it should be noted that the problem of hospital debts in Poland is not only multi-dimensional but also multi-layered. Hospitals are entities with a high level of fixed costs, and so they have limited possibilities to adapt to the dynamically changing market conditions (Malinowska-Misiąg, Misiąg & Tomalak, 2008, p. 30). A characteristic feature of indebted hospitals is excessive employment and escalating wage demands of healthcare employees. As a result, the source of the debt are not investment credits, but arrears, including those concerning social insurance contributions, receivables for suppliers and payroll liabilities. The experience of the last ten years clearly shows that debt relief programmes undertaken centrally have proven ineffective and, additionally, due to their recurrence they simply discouraged public hospitals to undertake restructuring activities (Pieprzyk, 2012, p. 48-49). The best proof of that is the experience with the Act on public help and restructuring of Polish hospitals, which, due to lack of mechanisms to allow supervision over the course of the restructuring process and lack of sanctions for abandoning a recovery program could not possibly have proven effective in hindering the process of incurring new liabilities.

FINANCING HOSPITALS AS CAPITAL COMPANIES. SELECTED FORMS

Regardless of the form of ownership, for all hospitals the main source of financing their activities is the money from contracts concluded with the National Health Fund (NFZ). For non-public local government hospitals, the contract with NFZ is also the basic source of financing, yet a source of hospital resources independent of NFZ and serving to improve their financial standing may also be an extended scope

of the services provided – enriched with treatments provided on a commercial basis, introducing additional hotel fees, or contracting health benefits with private insurers. At this point it is necessary to bring up two themes. Firstly, financing “medical activity” is only a part of the overall structure of hospital costs. Secondly, besides obtaining capital, financing in a broad sense includes also effectively managing it from the point of view of the material and financial processes conducted in hospitals. In accordance with that definition, besides obtaining capital, financing also includes everyday instructions which lead to maintaining financial stability, choosing methods to regulate expenditure, profitable investment of free financial resources, and making financial reports (Ickiewicz, 1993, p. 9). In view of the above, it was assumed in this paper that financing covers acquisition of capital in all its forms, i.e. both material and monetary, while taking into account the consequences of dividing the capital into own resources and outside capital, in the context of the activities of entities operating as capital companies.

With regard to the legal position of a capital provider in a company, one can distinguish own financing or debt financing. Both financing forms are available to the restructured hospitals. They may not only organise new issues of shares, but also issue debt securities, or make use of bank loans. Own financing includes financing with profit, contributions and shares. In all these cases, the company receives additional equity (increases the possessed capital) by payment of contributions or shares, as well as resulting from retaining some of the profit. Yet there is a difference between the three sources of fund supply. It consists in the fact that the obtained funds for own financing in the form of contributions and equity (contributory) financing are classified as external financing, and profit is generated within the company. In that connection, with external financing new rights and obligations for shareholders and partners appear, and if profit is retained in order to finance the company, one talks of self-financing. Outside financing includes financing with loans and funds accumulated in long-term reserves.

The decision of choosing the financing method is not only strategic from the point of view of the hospital's further development, but it is also connected with the need to conduct many analyses and processes. One of the ways of subsidising a capital company, such as e.g. a limited liability company, may be making

additional contributions. Partners are reluctant to use that because the refunding procedure is slow. The additional contributions are temporal contributions of partners. They do not increase the shares of partners, and thus they do not increase the company's share capital. The company's own funds do increase, however, which positively affects its financial image. The amounts and time of making additional contributions is decided at a shareholder meeting. A resolution in this matter is adopted by an absolute majority of votes (unless the articles of association provide otherwise). The issue has been settled in a radically different way than in the case of setting additional contributions, which arises from the fact that establishing the amount of surcharges and the time of paying them does not increase the benefits of partners but only clarifies their due date.

Another way of financing a company is increasing the share capital. The solution is common and is a universal formula for subsidising capital companies. Essentially, the process consists in increasing the nominal value of the capital, which is reflected in increasing the nominal value of already existing shares or issuing new ones. Increasing the share capital may be done on the basis of the existing provisions of the articles of association (simplified increase) or by changing the articles (ordinary increase). To be able to use the first way, relevant provisions must be included in the articles of association. The maximum amount of the increase and the time limit for it must be indicated. It is vital that shareholders' decisions to increase the share capital in that way do not require the form of a notarial deed to be valid. An important part of the process of increasing capital is acquiring new shares or their increased value. In the case of ordinary increase, it is possible for existing or new partners to acquire shares, whereas in the case of simplified increase new shares can be acquired only by current partners.

An alternative approach to financing the company is a loan. As an institution of civil law, it is a primary and at the same time a rather simple loan activity. From the viewpoint of a hospital's (a company's) functioning, a loan may be an effective form to subsidise its activity. If the loan is granted by a company partner, it is necessary to pay attention to the special stipulation of article 14 § 3 of the Code of commercial companies²³ which states that the

²³ Act of 15th September 2000 – Commercial Companies Code (Dz.U. of 2000, No. 94, item 1037 as amended).

partner's liability under the loan granted to the company shall be considered his/her contribution to the company in the case of announcing its bankruptcy within 2 years from the date of concluding the contract of loan. The above regulation provides some restrictions on protecting a partner's equity. Thus, the provision should be taken into account particularly by those partners who wish to subsidise the company (the hospital) in order to avoid its bankruptcy.

A loan granted to a hospital (company) by a shareholder is a common source of financing. A loan from a partner is exempted from tax on civil law activities, yet if a loan is granted by a partner who is a VAT payer – regardless of whether the partner grants loans within their activity – it may be subject to VAT. For a Polish shareholder, granting a loan (treated as a financial service) will be subject to VAT exemption. A loan granted by a foreign shareholder who is a VAT payer for a limited liability company will, in turn, be settled as import of services with all the tax consequences. In a situation when the loan is remitted, the amount of remission constitutes revenue for an ltd company, but in the case of interest remission, the latter do not constitute tax-deductible costs for an ltd company. The remitted interest may be treated as gratuitous service being the borrower's revenue. If an ltd company is granted a loan intended for investment-related purposes (e.g. purchasing fixed assets or intangible and legal assets), the interest charged by the date when the fixed asset or intangible and legal assets are transferred for use increase their the initial value and become a tax-deductible cost through depreciation write-offs.

Mezzanine capital may constitute an innovative and alternative source of financing a hospital's development, but one that will generate positive future flows. In finance, mezzanine means a hybrid financing form that contains elements of debt and equity. The basic features of mezzanine are as follows:

- 1) like regular debt, using mezzanine financing is interest-bearing,
- 2) mezzanine capital may be charged upon assets of the recipient company (it is usually, however, the security is secondary to the security for a bank),
- 3) a mezzanine agreement is similar in structure to a loan agreement, but for mezzanine providers future cash flows of the recipient company are of key importance,
- 4) interest is usually paid off at the beginning and the capital itself is returned at the end of the funding period in increasing instalments,

5) the period of investment is usually 5 to 7 years.

Mezzanine capital is one of the types of private equity - risk capital addressed to non-stock companies at different stages of their development. Besides mezzanine, private equity also includes venture capital, financing management buyouts and other types of financing. In the balance sheet of a hospital which is a capital company, mezzanine capital will be recorded as debt, despite the fact that it may give the lender the right to ownership structure (to shares/stock). Selected financing tools have been envisaged for a mezzanine: subordinated loans with a warrant of purchasing shares and bonds convertible into stock. Mezzanine capital is very often treated by banks as the borrower's equity. Another mezzanine instrument are bonds convertible into stock and bonds with a warrant. In exchange for lower maintenance costs of a current bond (lower value of a coupon/interest) the issuer allows a share in the equity. In the case of convertible bonds it means converting bonds into shares, while in the case of bonds with a warrant it is synonymous with purchasing shares at a specified price. For investors, such a conversion into a share of the equity is an important incentive when buying out securities with a lower interest rate.

An interesting alternative for the financing forms discussed above is equity from retained profit, which presents the owners' contribution into the growth of hospital capital as a capital company. The size of the capital thus gained is limited by the profit amount and the amount of dividends paid. Equity from the retained profit is not devoid of costs. Resigning from current dividends, shareholders demand other compensation, for example in the form of higher share prices or higher dividends in the future. That way of increasing equity is an alternative to issuing new shares, and at the same time it allows the company's current shareholders and owners to maintain the control they had so far over the company.

Venture capital investments are investments in dynamic entities in early stages of their development or those such as look for financing sources for further dynamic development. Thus, they fit the convention of hospitals operating as capital companies. Lack of an extensive track record does not mean lack of experience in conducting the business. An entity's stage of development results in higher investment risk and, what follows, a higher rate of return expected on investment that the potential investor will demand. When considering a venture capital investment,

the potential investor bases the decision on three main conditions. The basic one is the potential of a given entity's growth during the next few years. That potential is understood as both potential of the target market for the particular entity in terms of scope and territory, and the internal potential of the given entity. That means that the entity seeking venture capital financing should be active in a highly dynamic market which generates a constantly growing demand due to fundamental (demographic) factors.

In the case of hospitals operating as capital companies it is worth considering also private equity investments which are investments in mature entities seeking financing sources for further development and market consolidation. An extensive track record means it is possible to trace back the efficiency of managing the hospital as a company. That situation results in reduced investment risk and, what follows, lower rate of return expected on investment that a potential investor may demand. When considering private equity investment, the potential investor bases the decision on three main conditions. The basic investment condition here is the potential of a given entity's growth during the next few years, and its current market position and shares. An entity which seeks private equity financing should be active in an expansible market which generates a constantly growing demand due to fundamental factors. From the inside, in turn, such entities should have a high degree of quality in terms of product and of the business model. Furthermore, in the case of a private equity type of investment, an important issue is also the potential of market consolidation and thus getting significant competitive advantage and synergy effects. Gaining a strategic investor and acquiring financing from that group of entities is a process in which, apart from obtaining funds, a company (a hospital or a group of hospitals) also aims at taking advantage of the potential synergies resulting from the merger of entities (hospitals) and improving the competitive position resulting from economies of scale. The process can be carried out both with mature companies, which have a well-established market position, and hospitals which are developing companies, and among ones that have a strong position in a market niche, advantageous infrastructure and/or unique know-how. In the former case, the investment premise is to improve the competitive position, broaden the market and use the potential synergies. In the latter case, the investment premise is to use

the development potential and unique knowledge of the entity. The risk level connected with merger and takeover processes depends both on whether full control over the intercepted entity is taken over, and on the differences in the organizational culture of both entities, and finally also on the business model describing the acquired/merged entities.

Private issue of shares is a process in which hospitals operating as capital companies gain funds for development and achieving critical mass, or during which a new partner is allowed in the company. However, private issue is usually a stage preceding public issue, and for that reason it often takes a form of a pre-IPO²⁴. Companies which decide on private issue usually have a few years of history behind them, and a track record documenting their experience in their field of business, which allows them to quickly build foundations for public issue. That situation results in investors perceiving the risks of investment in such companies as being close to the risk in private equity investments. The basic investment premise when planning private issues is the potential of a given entity's growth during the next few years, achieved both by developing productive capacity and by market consolidation. A vital question here is also the potential to optimise costs which results from extending the scale of activity, and margin growth resulting from improving the competitive position. The stability of the generated cash flows from operational activities is also considered when making investment decisions. Just as it is with other methods of obtaining equity financing, here a strong equity story, as well as the competitive edge of the entity, are key factors determining whether it is possible to use that source of financial support for capital companies. Issuing high-yield bonds is a way of obtaining financing that is characteristic for entities which are not in a very good financial condition, or entities seeking to finance a high-risk venture. Instruments of that type are often used to obtain financing for restructuring ventures or for takeover of other entities. Due to the increased risk of such investment ventures, essential are the questions of the level of security of the issuer as well as evaluating the feasibility of the venture to which the funding is to be allocated. The latter issue is particularly important in view of the

²⁴ A pre-IPO is a private offer preceding the first public offer, aimed at obtaining funds providing a way to build a hospital's potential and adjust the hospital as a capital company to the requirements related with conducting an IPO.

fact that entities obtaining such financing often do not have a sufficient security level, or the security and its valuation do not meet sufficient quality requirements. An undeniable advantage of that form of financing, besides competitive financial costs as compared to other paths, is definitely a high degree of predictability for the period for which the financing is obtained. It also happens that such bonds take the form of convertible bonds, which is connected with the possibility to convert them into shares.

A loan and obtaining financing on its basis serve to intensify investment activities, sales or marketing of an entity. It also often allows them to release some of the entity's own resources, which in turn allows for accomplishing new (other) ventures. However, one ought to remember that it is an instrument which requires an entity to have high creditworthiness and a security set accepted by the entity which provides the financing. There are many parameters which decide how the instrument will be qualified and determine its usefulness for an entity conducting business activity. The basic ones include credit value, credit period and cost of the credit. Yet to fully assess the usefulness of the instrument, one should analyze the overall lending conditions occurring in a particular case. Thus, when considering the value of the granted loan, it is necessary to examine not only the overall amount of the credit or the value of the available credit line, but also how the way of accessing resources is adjusted to the needs of the entity, and the conditions which must be met in order to obtain the possibility of using particular tranches of the obtained funds. Essentially, there are three basic ways of making the obtained funds accessible to the entity. The first one is transferring them all at once, the second is payment in tranches, and the third is a flexible credit line. In many cases, credit agreements contain a number of exemptions which pose a risk for the continuity of payment if the granted funds are to be paid in tranches. That risk can also be understood as the risk of maintaining original credit conditions if external conditions or indicators inside the entity (i.e. the hospital) change.

Finance lease is a popular form of financing the purchase of assets by business entities, yet it is not as popular as an operating lease. Such a situation is mainly caused by the amount of the required own contribution connected with the first instalment and distributing tax deductions over time. Globally, it must be concluded that the instrument of lease

allows entities to access the assets without having to pay high expenses connected with their acquisition all at one time. The tax aspect should be considered the main criterion for qualifying a lease. A lease is an instrument based on future operational flows from the conducted activity, and not on currently possessed financial resources. Thus, it quickly gains in importance and popularity among both entities which do not have significant financial resources, and entities wishing to increase their tax deductions in a current period or ones which do not want to encumber their balance sheet. In the case of finance lease, the main qualifying features include placing depreciation deductions on the side of the lessee in whose balance sheet the lease-financed asset is included. Another factor that is typical of a finance lease is the fact that the lessee includes only the interest part of the lease instalment and depreciation in tax-deductible costs. An operating lease is the most popular form of the instrument. That is due to both lower capital requirements connected with the amount of the first instalment, which, unlike in a finance lease, does not include the whole VAT, and also due to a greater degree of tax deductions in the first period of the lease agreement. A distinctive feature of that type of lease is including an asset among the assets of the lessor who makes depreciation deductions. The lessee's tax-deductible costs include both the capital part and the interest part of a lease instalment. Leaseback is a special lease form in which the entity which owns the assets sells them to the lessor and then signs a lease agreement with it on that asset. Also, that form of lease most often takes the form of an operating lease. The instrument is used mainly to increase liquidity of an entity which does not want to freeze funds in fixed assets, or which, for various reasons, cannot obtain funds from other sources, such as a bank loan. That very interesting instrument generates many benefits for the lessee-entity because it helps it fully exploit the potential of its fixed assets. At the same time, the instrument helps to better manage the company and its medium-term liquidity, and optimize a company with a view to taxes.

PROS AND CONS OF FINANCING A HOSPITAL WITH OWN AND OUTSIDE RESOURCES

Both own and outside resources have their advantages and disadvantages as a source of financing assets of an

enterprise (company). The main advantages of own resources are as follows:

- 1) they are a stable financing source for the company's activities,
- 2) obtaining them does not involve compulsory interest, as it is in the case of a credit or a loan,
- 3) they help increase the liquidity of the company,
- 4) they provide a reliable warranty basis for creditors,
- 5) capital engaged for an indefinite period is the basis for creating ownership relations, which give the right to participate in profits.

The main disadvantage of own resources is the fact that they do not always bring benefits, especially when the company has losses. In capital companies, participation in financing losses is limited to the contribution amount or the value of the shares held. What is important, however, is the fact that losses diminish own resources. Moreover, if the enterprise is bankrupt and liquidated, the owners' claims are satisfied after paying liabilities to various creditors. Therefore, own resources are much less flexible as compared to outside resources. Other disadvantages of own resources are also:

- 1) high cost of acquiring and managing them,
- 2) their relatively limited amount,
- 3) payments of profits for the owners, which do not constitute a financial cost.

Outside capital has a number of advantages, which include among others:

- 1) flexibility in funding (own resources lack this feature),
- 2) the capacity to undertake and implement projects which exceed the company's financial capacity,
- 3) the possibility to lower the tax burden and increase share capital profitability,
- 4) no voting rights of a creditor (usually) in making decisions in the enterprise,
- 5) providing the possibility to create the optimal capital structure in the company.

Outside capital, however, is not devoid of defects. Using that financing source should therefore be corrected for the potential drawbacks following its application. Negative effects of involving outside capital consist mainly in the following:

- 1) it is at the enterprise's (company's) disposal for a limited time, after which it must be returned,
- 2) creditors have the right to interest,

- 3) obtaining outside capital often requires security or warranty,
- 4) during an inflationary period, creditors may demand additional warranties to ensure the real value of the borrowed capital,
- 5) risk and cost of outside capital usually grow together with the debt of the enterprise,
- 6) a high degree of debt may even lead to granting certain powers to creditors,
- 7) in the case of the enterprise's liquidation, creditors are paid before the owners.

In practice, most companies use outside capital to cover their current and developmental expenses. In financially stable companies, paying some liabilities is connected with incurring others. Therefore, a company which has the required creditworthiness and sufficient financial liquidity, and is considered a reliable debtor, should not have problems obtaining outside capital. In such a situation, outside capital is a convenient financing source and therefore usually occurs in the balance sheet of a company as a constant. Only its amount and structure change, e.g. due to the possibility to refinance loans accordingly to the financial needs and investment plans.

An important feature of outside capital is also the fact that, despite lack of its own resources, the company may undertake activities on wider scale. Involving outside capital may be beneficial also in terms of the tax burden. If the interest on outside capital is included in tax-deductible costs, then reducing the tax base reduces also the amount of income tax. The situation is completely different when the activity is funded with own resources. The owner of the contributed capital does not receive interest, but participates in the profit. If the profit share is treated as a payment (cost) for the contributed capital, the payment is taxable under income tax charges on the profit. Finally, outside capital also contributes to using what is called the financial (economic) leverage effect, and its positive effect means the same as increasing profitability (cost-effectiveness) of own resources as a result of involving outside capital.

CONCLUSIONS

Assessment of the financial situation of the healthcare sector in Poland shows that hospitals constantly get into debt. That results from their costs not being balanced with revenues (Golinowska, 2008). In fact, public entities of the healthcare sector substantially

give credit for NFZ and the public system of healthcare services. This stems primarily from shifting the consequences of imbalance of the system's revenues and costs of medical services onto public hospitals. That solution, while protecting NFZ against debt, directly affects service providers. In addition, if an SPZOK generates losses, local governments guarantee loan pay-off to hospitals, provide non-refundable loans or remit their payment. That causes further increase of the debt of the local public finance sector and escalation of debt servicing costs. Adding to that the fact that independent public healthcare centres belong to PFS, and so they are entities whose priority is not economic profit but meeting the collective needs of society – a loss should be considered a fully predictable result of providing healthcare services in that organizational form. In the present state of law, local government units as establishing bodies have limited scope of intervening within SPZOK financial management. The influence of self-government authorities on their operation is in principle limited to intervening at a stage when the liquidity of the units is at risk. That fact provides a determinant for transforming hospitals into capital companies joining the current lack of possibilities of direct intervention of LGUs into activities of SPZOKs with the necessity of independent (i.e. excluding direct support from LGUs) financial management. Thus the company's form requires shifting responsibility for the shape of the financial management onto the hospital, lifting the risk of financial burden to the funding entities, including in particular LGUs.

Transforming SPZOKs into commercial companies should result in more favourable employment parameters, the number of services provided, greater spending on preventative care and health promotion. Yet one cannot talk of simply transferring the management methods from the private sector to “newly formed” non-public hospitals – even though their founding body is public. That stems from the fact that, from the financial point of view, the newly formed company is a specific constitutional form (e.g. that of local government) of an entity providing healthcare services, and thus it does not lose its public nature. As a result, it should be stressed that a thus originated entity in this way is not entirely subject to sectoral regulations. That, in turn, means that new regulations concerning financing such entities by the founding bodies, including e.g. local governments

are by all means desirable in that area (Grzeškiewicz, 2011, p. 89).

Yet at the same time, transforming hospitals into companies is inevitable. It is shown e.g. by the fact that overdue liabilities of hospitals increased just in 2011 to a level of almost 3 billion zlotys. Restructuring hospitals brings more and more money to private companies. The largest of them earned over 42 million zlotys in the previous year alone²⁵. Private hospitals functioning in Poland do not have problems obtaining funds. Banks generally do not refuse to support them when they apply for funds for investments. State hospitals do not have such possibilities. Banks do not want to finance indebted hospitals, and if the establishing entity cannot support them, they are left to their own means. So private companies, specialized in providing such assistance, become their hope.

On 1st July 2011, the Act of 15th April 2011 on medical activity entered into force. It introduced big changes e.g. in the functioning of hospitals, ways of establishing and financing them. On the same day, the Act of 30th August 1991 on healthcare centres became invalid. The Act provides for the possibility to transform an SPZoz into a commercial company. In the previous legal status, “transformation” was done by liquidating the SPZoz and founding a commercial company in place of the liquidated centre.

For hospitals which obtained resources from EU funds, that “transformation” gave rise to significant concerns from the viewpoint of maintaining the rule of project sustainability. As expected, the Act does not assume the conversion of SPZozs into companies to be compulsory, yet the local governments which do not transform the hospitals, will have to cover their losses within 3 months of the deadline for financial statement approval. If they fail to comply with that duty, being the leading bodies (owners), the LGUs will be forced to transform hospitals into capital companies or budgetary units, or to liquidate them, within one year. That, in turn, may cause the optional nature of the transformation to actually prove fictitious. Moreover, the new Act introduces many controversial solutions, which include e.g. imposing just one way of transforming the SPZozs regardless of whether they are hospitals or open healthcare facilities. The changes introduced by the Act do not resolve the gist of the matter, as the main source of revenue for hospitals are still the resources from contracts concluded with NFZ while the mode and principles of functioning of the inefficient NFZ have been left unresolved.

25 Ministry of Health, www.mz.gov.pl.

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- Act of 27th August 2009 on public finance (Dz.U. of 2009, No. 157, item 1240 as amended).
- Act of 30th June 2005 on public finance (Dz.U. of 2005, No. 249, item 2104 as amended).
- Act of 30th August 1991 on healthcare centres (Dz.U. of 2007, No. 14, item 89 as amended).