ARGUMENTA OECONOMICA
No 1 (28) 2012
PL ISSN 1233-5835

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SOURCES OF SOFT BUDGET CONSTRAINTS IN THE STRUCTURE OF AUTONOMOUS PUBLIC HEALTHCARE CENTRES [1]

Most of the public hospitals in Poland are heavily challenged to meet the costs of their operations. They are in severe debt and many of them face the risk of insolvency and loss of operability. Since a huge majority of Polish hospitals are operated by local authorities, we decided to focus just on this type of hospitals in this paper. However, our conclusions may as well be generalized to cover all the autonomous public healthcare centres.

In this paper we discuss the sources of soft budget constraints, inherent to the legal form of autonomous public healthcare centres. We start with presenting the concept of soft budget constraints and point out the relationships between the concept and the insolvency of hospitals operated by local authorities and of the local authorities. The second part deals with the mechanisms of soft budget constraints development. The third part presents the nature and principles of financial governance of autonomous public healthcare centres. The fourth part is a listing of changes in the operating principles of healthcare service providers. The final discussion focuses on the consequences of financial instability of autonomous healthcare centres borne by their founding bodies.

Keywords: soft budget constraints', healthcare service, autonomous public healthcare centres

INTRODUCTION

A soft budget constraint is a very specific social institution. It consists in the existence of entrenched, universal expectations of the participants to a social interaction that one party to a commercial or social contract will be disposed to directly or indirectly cover the financial shortages of the other party. Such soft budget constraints may be among major causes of the mass insolvencies in various entities, including the local authorities and the units operated by them.

The legal and organizational framework of an autonomous public healthcare centre is a classic example of an entity exposed to soft budget constraints. The

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[1] Parts 2 and 3 use fragments of the article by Arkadiusz Babczuk, *Mechanisms for preventing local authorities' insolvencies* draft.

aforementioned analysis proved this type of constraints to produce a specific industry belief that an autonomous public healthcare centre may not cover its own liabilities. This creates a flaw which naturally wastes a large part of the efforts and energy spent on increasing the entity's efficiency. The enormous inertia has its tangible financial dimension, visible in the multi-billion, systemic debt. The time spent waiting for elimination of this dysfunction has proved wasted. The lack of systemic solution gives rise to individual initiatives, making use of the existing, but highly complicated legal opportunities. At the end of 2011, in Poland there were over 71 hospitals operating as municipal companies. They performed quite well in the difficult market for healthcare services. Those innovations generally confirm the possibility of effective elimination of the dysfunctions described here through a transformation of the business formula of healthcare service provision into one subject to hard budget constraint.

Public access to healthcare services constitutes a standard in any modern European welfare state. In Poland, the healthcare services provided under the national health insurance system are financed by the National Health Fund [Narodowy Fundusz Zdrowia – NFZ]. The primary and outpatient specialist healthcare services are provided under individual contracts finalized with NFZ by the non-public healthcare establishments as well as the autonomous public healthcare centres whose founding and supervisory bodies are the local authorities of a commune level (*gmina*). Hospitals are usually operated by the second-tier (*district*) local authorities. Some of the major hospitals operate as autonomous public healthcare centres whose founding and supervisory bodies are the third-tier (*provincial*) authorities. The specialist teaching hospitals are usually operated by public medical universities. There are also a couple of hospitals supervised by individual governmental ministries, e.g. the Ministry of Administration and Home Affairs or the Ministry of National Defence. Finally, several dozen of hospitals have formed shareholding companies, operating non-public establishments which also provide public healthcare services under individual contracts with the NFZ.

Most of the public hospitals are heavily challenged to meet the costs of their operations. They are in severe debt and many of them face the risk of insolvency and loss of operability. Since the huge majority of Polish hospitals are operated by local authorities, we decided to focus just on this type of hospital in this paper. However, our conclusions may be generalized to cover all the autonomous public healthcare centres.

The insolvency of the healthcare establishments operated by local authorities ('local public healthcare establishments') would have serious consequences of an economic, social and political nature. It might result e.g. in the cessation or limiting of the scope of healthcare services provision. The

insolvency of local public healthcare establishments could also bring insolvency to the local authorities involved, and consequently disintegrate the entire system of public service provision to the local community. It could also bring pressure on the national government to bail out the local public healthcare establishments and local authorities suffering financial hardship. If the government succumbs to the pressure, the expected bailout might become one of the major determinant of the attitudes of both local healthcare managers and local authority decision-makers. The insolvency of the local public healthcare establishments and of the local authorities themselves might then become a mass phenomenon. This, in turn, might bring about a significant deterioration of the national budget balance and an increase in both public debt and the inflation rate.

In this paper we discuss the sources of soft budget constraints, inherent to the legal form of autonomous public healthcare centres. We start with presenting the concept of soft budget constraints and point out the relationships between the concept and the insolvency of hospitals operated by local authorities and of the local authorities. The second part deals with the mechanisms of soft budget constraints development. The third part presents the nature and principles of financial governance of autonomous public healthcare centres. The fourth part is a listing of changes in the operating principles of healthcare service providers. The final discussion focuses on the consequences of financial instability of autonomous healthcare centres borne by their founding bodies.

1. THE CONCEPT OF SOFT BUDGET CONSTRAINTS

The term ‘soft budget constraints’ was first used by János Kornai (1979) with reference to the specific relations between enterprises and governmental authorities in centrally-planned economies. In his opinion, the nature of budget constraints determines the behavioural response of decision-makers. If the budget constraint is ‘hard’, the managers would (*ex ante*) adjust the expenses of the managed enterprise to the financial gains they expect from product sales or any other interest in the assets held (Kornai, 1979; Kornai, 1986; Kornai, Maskin, Roland, 2003). Therefore, a hard budget constraint (*ex ante*) restricts the behaviour of business entities. *The softening of the budget constraint occurs when the strict relationship between expenditure and earnings has been relaxed because an excess of expenditure over earnings will be paid by some other institution, typically by the State* (Kornai 1986). Thus the budget constraint ceases to restrict the behaviour of decision-makers.

Mathias Dewatripoint and Eric Maskin define soft budget constraints as a propensity of the supporting entities to bail out other organisations in their drive to avoid losing the profits from previous expenditure. At the same time, this attitude of the supporting entities is expected by the organisations bailed out (Kornai, 1986).

Babczuk (2008) is of the opinion that soft budget constraints have the characteristics of a social institution. They consist in entrenched, universal expectations of the participants to a social interaction that one party to a commercial or social contract will be disposed to directly or indirectly cover the financial shortages of the other party. Budget constraints are 'soft' solely when the decision-maker expects such external financial aid with a high probability. Soft budget constraints would have no strength or importance if they did not shape the expectations and attitudes of the surrounding entities, first of all of the stakeholders of the assisted party to a commercial or social contract.

Kornai (1979, 1980) holds the opinion that a single instance of occasional assistance to an enterprise will not produce the soft budget constraint phenomenon. It is only a continual or very spectacular assistance to the loss-producing enterprises that can entrench the expectation for such practices to continue in the future. According to János Kornai, the basic premise of soft budget constraint development is the paternalistic attitude of the state towards the enterprises.

Kornai (1980) also expresses another opinion worth mentioning here, namely that there is actually a continuum of budget constraints, delimited at one end by the absolutely soft budget constraint and at the other by the absolutely hard one. To keep matters simple, the subject literature usually uses the terms of soft or hard budget constraint in the meaning of a budget constraint that is close enough to the respective continuum limit. However, given their awareness of the graduating scale of budget constraints, the researchers tend to refer to the 'softening of budget constraints', in the sense of a gradual shift towards the absolutely soft budget constraint.

Although the concept of soft budget constraints was originally used with reference to centrally-planned economies, especially those under 'reform', the phenomenon may occur in different economic environments and it is not limited to the relations between public authorities and state-owned enterprises. The problem of soft budget constraints also refers to e.g. private industrial corporations, financial services brokers, various organizations like hospitals, schools or universities as well as local authorities. The same symptoms are also visible in international relations. Soft budget constraints occur in countries going through the transformation from central planning to a market

economy, but also in stable capitalist economies. (Aghion, Bolton, et al. 1999; Duggan, 2000; Kornai and Eggleston, 2001; Fischer, 1999; Mitchell, 1998, 2000; Moesen and van Cauwenberge, 2000; Tornell, 1999; Wildasin, 1997)

With reference to the healthcare establishments operated by local authorities, the problem of soft budget constraints may appear on various planes (Fig. 1). It may show up in the relations between a healthcare establishment and the local authority who is its founding and supervising body. In such a situation, the decisions made by the managers of the healthcare establishment are affected by their belief that the local authority will bail out the establishment in the event of financial hardship. However, an attempt to shift the debt load from the healthcare establishment to its founding authority may result in financial difficulties for the local authority itself. Therefore the decision-makers of both the local authority and the healthcare establishment may expect a bailout from the national government.

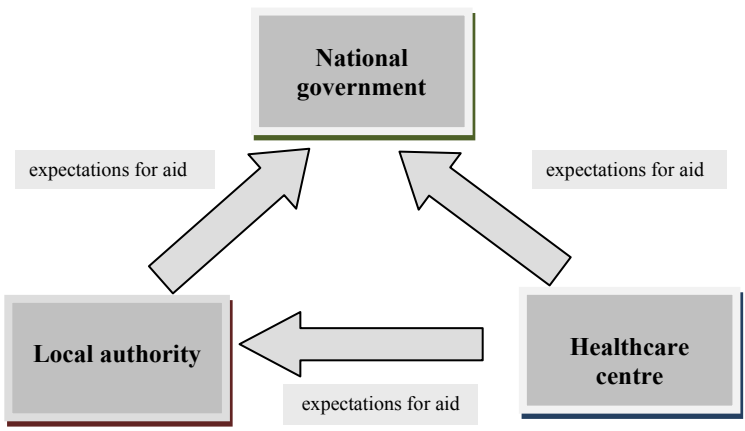

Fig. 1. Aspects of local healthcare establishments where soft budget constraints may occur
Source: own research

If the managers of entities operated by the local authorities as well as the decision-makers of the local authorities are convinced they will be bailed out by the national government whenever a threat of insolvency occurs, they may, for instance:

- consciously accumulate debt they are unable to pay back, e.g. by financing excessive investments out of repayable funds, which might be called a 'subsidy-extraction game',
- shoulder excessive risks in their financial management, e.g. by paying too little attention to the reduction of excessive costs, especially

overheads, and by avoiding the effort of restructuring the entities operated by local authorities (Babczuk, 2008).

It should be noted that for the soft budget constraints to induce a repetitive and universal threat of insolvency of the healthcare establishment operated by the local authorities, the belief in the inevitability of bailout by the founding body or the state must be shared by the establishment's financial partners. The same applies to local authorities.

2. THE MECHANISMS OF SOFT BUDGETARY RESTRAINTS DEVELOPMENT

Let us consider a hypothetical relationship between two entities: the supporting and the supported one. The supported entity may be a healthcare establishment operated by the local authority, that expects support from both the operator and the national government. It may be also the local authority expecting support from the national government. The supporting entity will then be the local authority or the national government, respectively.

The evaluation of the local authority's and national government's propensity to offer support to the healthcare establishment, as well as the evaluation of the national government's propensity to offer support to the local authority, is based on the analysis and assessment of:

1. the existing legislation, defining the attitude of the supporting entity in the situation of the supported entity's insolvency,
2. the current and future power of the supporting entity, and
3. previous experiences of supporting the healthcare establishments and the local authorities in crisis situations.

The legislation defining the relations between the healthcare establishment, its founding body and the national government, as well as between the local authorities and the national government, may:

- lay down an obligation to bail out entities under insolvency threat,
- lay down a prohibition to bail out entities under insolvency threat, or
- contain no explicit regulation of the situation.

The basic factors determining the power of the local authority's and the government's executive bodies are their stability, integrity and decision-implementing capacity. In this context, the evaluation also covers their propensity to earn praise by transferring public money to individual local authorities or electorate groups. The power of the local authority's and the government's executive bodies depends to a large extent on the nature of the

political and budgetary structures existing in the given country (Alesina and Perotti, 1994).

The nature of budget constraints of local public healthcare establishments and local authorities is basically determined by their experiences with the support offered by their founding bodies and by the government. In fact, this is a strategic game going in loops. Results obtained at every stage affect the participants' expectation for the subsequent stages of the game (Fig. 2). Experiences are of particular importance in forming the entities' expectations when we reject the hypothesis that the parties to economic and social processes have absolutely rational expectations in favour of the concept of their procedural (induced) rationality (Rodden, 2006).

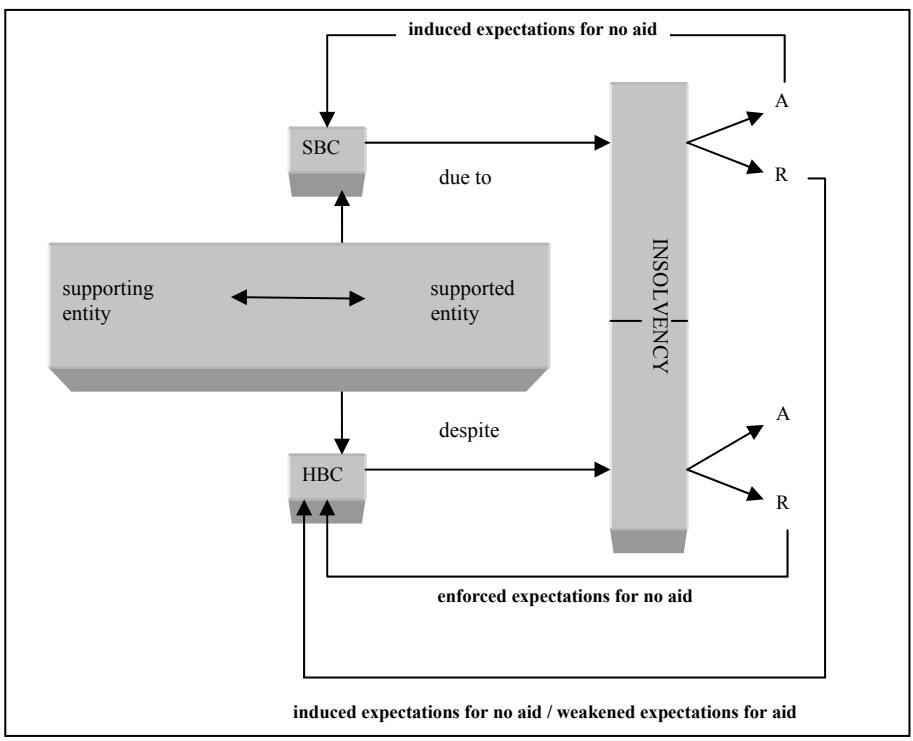

Fig. 2. The mechanisms of soft budgetary restraints development

SBC – soft budget constraint, HBC – hard budget constraint, A – aid provided by the supporting entity, R – aid refused by the supporting entity

Source: own research

Let us assume that at the starting point the supported entity faces soft budget constraints. In consequence, this entity may embark on actions resulting in the insolvency threat. In this situation, the supported entity demands assistance from the supporting entity. If the supporting entity succumbs to the demand, this will reinforce the expectations for obtaining assistance at subsequent stages of this strategic game (Fig. 2). A strict refusal might induce expectations for no assistance or at least weaken the expectations for obtaining assistance. In this way the soft budget constraint will get replaced by a hard budget constraint or at least get shifted towards the harder range.

It should also be noted that the existence of hard budget constraint does not exclude the possibility of the insolvency of the local public healthcare establishment or the local authority. However, the probability of insolvency is then significantly reduced. With permanently hard budget constraints, the prerequisites of insolvency are the problems with immediate access to full and relevant information obtained by the participants of social processes, which consequently limits their ability to formulate valid prognoses. Another significant factor may also be the risk of human error during the implementation of a correctly formulated strategy (operational risk). However, a detailed discussion of these risks is beyond the intended scope of this paper (Baldassare, 1998; Mikesell, 2002).

If in the situation of hard budget constraints the supported entity becomes insolvent, the lack of assistance from the supporting entity will enforce the expectation that at subsequent stages of this strategic game the supporting entity will still show no propensity to offer assistance. If, however, despite hard budget constraints the supporting entity decides to offer assistance to the supported entity which becomes or may become insolvent, this might induce the expectations for assistance at the subsequent stages of the game.

3. THE NATURE AND PRINCIPLES OF FINANCIAL GOVERNANCE OF AUTONOMOUS PUBLIC HEALTHCARE CENTRES

The legal framework for establishing autonomous public healthcare centres has been in place since the early 1990s. This legal and organizational formula of providing healthcare services gained no widespread popularity at the beginning. In 1996, when the Ministry of Health and Social Welfare started to implement the pilot project of Autonomous Public Healthcare

Centre, only 8% of public healthcare centres enjoyed this status (Klich, 2007). In the then adopted model of public healthcare, autonomous healthcare centres were intended to only supplement the system. This legal and organizational formula was dedicated only to healthcare centres able to finance their current operations. Other healthcare centres were still to operate as entities administrated by the state or local authorities. Thus the granting of autonomy was intended to mark the entity's outstanding performance within the public healthcare system.

The formation of a legal and organizational framework for the operations of such autonomous establishments was complete with the passing of the Law Amending the Healthcare Institutions Act and some other Acts of 20 June 1997 (Dz. U. [*Journal of Laws*] No. 104 of 1997, item 661). The Law introduced the concept of 'autonomous public healthcare centre' (samodzielny publiczny zakład opieki zdrowotnej – SPZOZ). The legal form of those centres proved to be imprecise, which made it a subject of the courts consideration at various levels (including both the Supreme Administrative Court and the Constitutional Tribunal). It is enough to say that during 1991-2009 the law was amended as many as 53 times. Despite these efforts, the lack of many basic definitions or a universal, generally accepted interpretation of some terms used therein has not been remedied (Dercz and Rek, 2007). In practice, this has resulted in numerous interpretative problems, at the same time increasing the risks related to the implemented management and restructuring actions.

The number of autonomous healthcare centres soared at the end of 1998. The then introduced reform of healthcare system assumed that only healthcare centres of an autonomous status will be eligible to enter contracts on healthcare service provision. Therefore, the transformation into an autonomous healthcare centre was necessary for the existing centres to continue their operations.

Until 30 June 2011 the basic legislation regulating the financial regime of autonomous public healthcare centres included Article 35(b) and (c) and Articles 50, 60 and 61 of the Healthcare Centres Act of 30 August 1991 (consolidated text published in Dz. U. [*Journal of Laws*] No. 14 of 2007, item 89 as subsequently amended). Article 35(b) provided that an autonomous healthcare centre would cover the expenditure related to its operations and liabilities independently (i.e. with their own resources and proceeds). Article 35(c) provided that the financial regime of an autonomous healthcare centre would be subject to the legislation regulating public funds management – during 2006-2009 this was the Public Finance Act of 30 June

2005 (Dz. U. [*Journal of Laws*] No. 249 of 2005, item 2104 as subsequently amended), formally replaced on 1 January 2010 by the Public Finance Act of 27 August 2009 (Dz. U. [*Journal of Laws*] No. 157, item 1240). Under Article 50(1), an autonomous healthcare centre was to follow the principle of efficient use of both the public assets in its administration and the public subsidies granted in all its operations. Article 60(1) provided that an autonomous public healthcare centre would cover any negative financial results of its operations also from its own resources and proceeds.

However, these principles were in conflict with other provisions of the Healthcare Centres Act of 30 August 1991. For instance, Article 61 did not specify the body to audit the annual financial statements (the Board or Council of the founding body, or maybe a social council). As a result, no consequences of failing to get the annual financial statement approved were provided for. Even though the procedure of acknowledgement of the fulfilment of duties is standard practice in the public finance sector, it did not apply to the CEO of an autonomous public healthcare centre. Such a solution had a strong negative impact both on the possibility of the owner's supervision of healthcare establishments and on the managers' sense of personal responsibility for the autonomous healthcare centre performance.

Article 60(2) of the Healthcare Centres Act of 30 August 1991 provided that a negative financial result earned by an autonomous public healthcare centre could not constitute the basis for winding up where the continued operations of the healthcare centre were justified by the objectives and tasks for which the healthcare centre had been established and which could not be taken over by another centre in a manner securing uninterrupted provision of healthcare services to the public. In such a situation, the obligation to cover the negative financial result earned by an autonomous public healthcare centre was shifted to the centre's founding body (Article 60(4) of the Healthcare Centres Act of 30 August 1991). This provision was the fundamental cause of the lack of sense of personal responsibility for financial performance among the managers of healthcare centres, and consequently of the lack of opportunities for the founding bodies to supervise the operating efficiency of their autonomous public healthcare centres. This provided the healthcare centre CEO with a guarantee that the financial result earned would have no impact on the centre's going concern.

At the same time it should be noted that the legislation does not provide the autonomous public healthcare centres with the legal capacity for bankruptcy. They could only get liquidated provided that a number of statutory requirements were met. However, this did not release the founding

body from the liabilities incurred by such an autonomous public healthcare centre. Article 60(6) of the Healthcare Centres Act of 30 August 1991 provided that the liabilities and receivables earned by an autonomous public healthcare centre prior to its liquidation would become the liabilities and receivables of its founding body.

In the opinion of many healthcare centre managers, those regulations defined the role of a founding body as consisting primarily in taking over the debt of autonomous public healthcare centres. It would be hard to prove this opinion flawed, since a founding body had no opportunity for the effective control and enforcement of efficient management of its autonomous public healthcare centre, while it remained fully liable for the financial result of such management.

A significant obstacle to ensuring the proper operation of healthcare centres was the insufficient regulation of healthcare centre managers' legal responsibility for the centre's performance. This resulted from the ostensible autonomy of autonomous public healthcare centres. The resultant situation was that the liability for the centre manager's decisions was borne by the centre's founding body. This violated one of the basic principles of efficient management, namely the principle of a close correlation of the decision-making powers with the liability for decision outcomes. It should be stressed here that this irregularity refers to the backbone of every organization – the financial regime. The Healthcare Centres Act of 30 August 1991 contained no provisions whatsoever on an autonomous public healthcare centre manager's liability for the centre having a negative financial result. They are also absent from the Public Finance Act of 30 June 2005 (Dz. U. [*Journal of Laws*] No. 249 of 2005, item 2104 as subsequently amended), as well as from the Public Finance Act of 27 August 2009 (Dz. U. [*Journal of Laws*] No. 157, item 1240). Neither does the development of a negative financial result for an autonomous public healthcare centre constitute an act giving rise to legal liability for the violation of the strict rules of public finance governance. It is only Article 16(2) of the Act on Violations of Public Finance Management Regime of 17 December 2004 (Dz. U. [*Journal of Laws*] No. 14 of 2005, item 114 as subsequently amended) which includes provisions which may be used as the basis for charging a healthcare centre manager with liability for his negligence or non-performance of financial management duties which resulted in the centre's failure to meet an outstanding liability. However, as the punishments applied are rather symbolic, their practical significance is marginal (Włodarczyk, 2003).

As a result of the above-mentioned dysfunctions, an autonomous public healthcare centre operating under the provisions of the Healthcare Centres

Act of 30 August 1991 was a newly invented, premature legal form, which – regardless of the intentions of the healthcare system reformers – made neither an autonomous public entity nor a component of the special administration system. Neither did it fit any formulas of integration with the various administration levels. Additionally, it had no place in the formation canon of public service institutions (state-administered entities, entities administered by the local authorities, and community partnerships). No wonder that the authors of research reports and expert opinions frequently described autonomous public healthcare centres as a formal and legal hybrid (Golinowska, Czepulis-Rutkowska, et al 2002; Boni, Kruszewski, et al 2003; Instytut Spraw Publicznych 2003).

Since 1 July 2011, the operations of healthcare service providers have been regulated by the provisions of Medical Service Law of 15 April 2011 (Dz. U. [*Journal of Laws*] No. 112, item 654 as subsequently amended). Article 7 of the said law provides that the Treasury (as represented by the minister, a central governmental agency or a province head), local authorities and medical universities may continue to operate medical establishments in the legal form of autonomous public healthcare centres. However, Article 204 of that law provides that they may not create new medical establishments in that form, with the exception of those created through mergers of the already existing autonomous public healthcare centres. Since 1 July 2011, the basic legislation regulating the financial regime of autonomous public healthcare centres and setting forth the rules of their legal and organizational transformations has been the provisions of Articles 51-82 of the Medical Service Law of 15 April 2011 (Dz. U. [*Journal of Laws*] No. 112, item 654 as subsequently amended). Article 52 of the Medical Service Law provides that an autonomous healthcare centre shall use its own resources and proceeds to cover the expenditure related to its operations and liabilities. Its Article 59(1) also provides that an autonomous public healthcare centre shall use the same to cover any negative financial result of its operations.

Additionally, sections (2) and (4) of its Article 59 set forth a mechanism that is intended to prevent the continuous accumulation of debts incurred by autonomous public healthcare centres. Within its framework, where an autonomous public healthcare centre 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 of such an autonomous public healthcare centre. The loss coverage must occur within three months from the date when such a

financial statement was audited and approved. If the loss does not get covered, the founding body shall have 12 months to commence the procedure of either a legal and organizational transformation or a liquidation of the autonomous public healthcare centre involved. Under Article 216 of the same law, the first fiscal year to which the above provisions shall apply shall be FY 2012. Consequently, 2013 will be the first year during which the founding bodies of autonomous public healthcare centres will have to decide either to cover their net loss on operations (as increased by the assets impairment loss) or to commence their transformation.

Additionally, Article 60(4) of the Medical Service Law provides that where a decision to liquidate an autonomous public healthcare centre has been taken, the total length of the liquidation procedure shall not exceed 12 months. Under Article 60(6) of the law, the assets, liabilities and receivables earned by an autonomous public healthcare centre prior to its liquidation shall then become the assets, liabilities and receivables of its founding body.

Where a decision has been taken to transform an autonomous public healthcare centre into a commercial company, prior to executing a transformation deed, the founding body will have to calculate a debt ratio of such an autonomous public healthcare centre. Article 70 of the law provides that the debt ratio shall be calculated as the proportion of a total of long- and short-term liabilities, less short-term investments, to a total of income earned by such an autonomous public healthcare centre. Where the debt ratio thus calculated exceeds 50%, the founding body shall have to take over the liabilities of the autonomous public healthcare centre involved in the amount ensuring that on the day of the transformation of this autonomous public healthcare centre into a commercial company the debt ratio of such newly formed company does not exceed 50%. Where the debt ratio thus calculated does not exceed 50%, the founding body may take over the liabilities of the autonomous public healthcare centre involved at its own discretion. This creates the possibility for establishing medical service operators who will be significantly indebted from day one. Such a financial position will obviously have an adverse impact on their market situation.

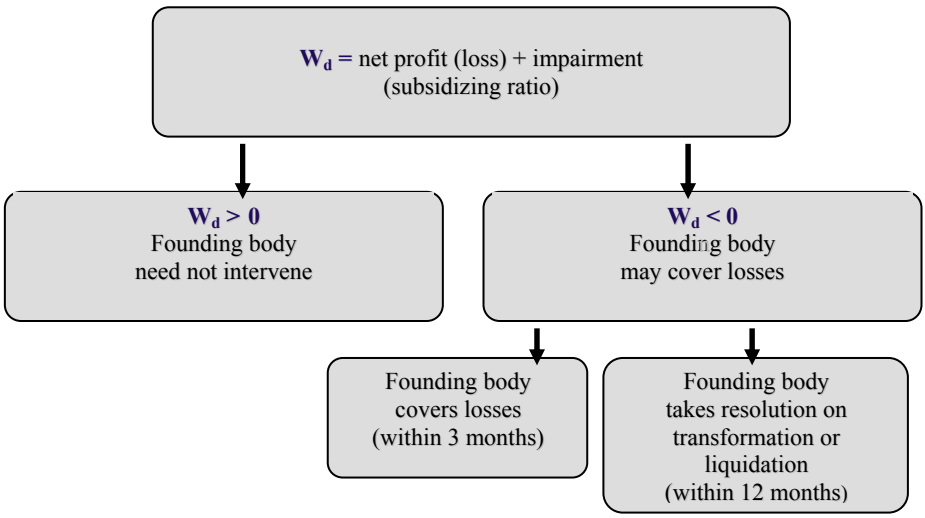

Fig. 3. Scheme of taking the decision to cover the losses or to implement transformation

Source: own research

Article 77 of the Medical Service Law provides that within the transformation procedure the founding body shall execute a deed of transformation of an autonomous public healthcare centre into a commercial company. The effective date of such a transformation shall be the day of such a company obtaining registration with the Companies' Register. Article 80(4) of the same law provides that on the effective transformation date the commercial company thus established shall inherit all the rights and obligations of the previously existing autonomous public healthcare centre. Additionally, Article 81(1) of the same law provides that on the effective transformation date the employees of the transformed autonomous public healthcare centre shall become the employees of the successor company by virtue of law.

In order to secure the interests of both the medical service providers operating as autonomous public healthcare centres and their founding bodies, the legislative decided to limit the possibilities of speculative trading in the liabilities of autonomous public healthcare centres. Under Article 54(5) of the Medical Service Law, a legal act intended to assign the liabilities of an autonomous public healthcare centre may only be executed upon consent from the founding body. The founding body may grant or refuse such a consent as it deems fit to secure the ongoing medical service provision and upon analysing the financial standing and financial performance

of the autonomous public healthcare centre involved during the previous fiscal year. The consent may only be issued in consultation with the CEO of the autonomous public healthcare centre involved. Failure to obtain such consent from the founding body of the autonomous public healthcare centre involved shall render any such assignment of liabilities ineffective in law.

The factor which heavily contributes to the lack of sense of personal responsibility for financial performance among the managers of autonomous public healthcare centres as well as many decision-makers of their founding bodies is the repeated experience of obtaining public aid. This also affects the attitudes of the healthcare centres' business partners.

In 1994 and 1995, healthcare establishments were assigned additional funds from the national budget to cover the due liabilities totalling PLN 2 billion. In 1997, the State Treasury covered the liabilities due from healthcare establishments to the total of PLN 1.7 billion Another debt reduction took place in 1998 and amounted to over PLN 8 billion (Młodzianowska, 2006). This means that the total bailout provided to the healthcare establishments by the State Treasury during the 1991-1998 period amounted to PLN 11.7 billion (Najwyższa Izba Kontroli, 1999).

During 2005-2008, public aid to healthcare establishments took the form of loans. The loans were offered under the Act of 15 April 2005 on public aid and restructuring of public healthcare centres (Dz. U. [*Journal of Laws*] No. 78, item 684 as subsequently amended). The aid was obtained by the total of 868 autonomous public healthcare centres. The vast majority of them were establishments founded and operated by district and provincial authorities. The total amount of loans offered was nearly PLN 2.2 billion, and as much as 70% of the loan amount could be written off retired upon successful completion of the centre's restructuring process (Najwyższa Izba Kontroli, 2008).

Another promise for assistance to locally operated hospitals were included in the draft bill on healthcare centres, prepared by the Ministry of Health and presented to the Polish Parliament (Sejm) in 2008 as an initiative of a group of MPs belonging to the ruling coalition (Sejm, 2008). The bill was passed by Parliament on 6 November 2008. However, the President vetoed the bill and the Parliament did not manage to overrule the veto. Therefore the government adopted a multi-year Action Plan of '*Supporting the local authorities in their actions aimed at stabilizing the public healthcare system*' (the so-called Plan B). The Plan was rooted in the extant regulations on public healthcare centres and provided for public aid in settling the public-law liabilities incurred by autonomous public healthcare

centres, subsequently transformed into commercial medical service providers, and taken over by the founding bodies upon such transformation.

The plan was implemented during 2009-2011 and was assigned a total budget of PLN 1,381 million. The aid was to be granted for the repayment of public-law liabilities of autonomous public healthcare centres or their civil-law liabilities still payable after negotiating settlements with creditors, or for covering the value-added tax due on assets in-kind brought into the newly formed commercial medical services providers by the local authorities to pay for their shareholdings. The plan did not provide for any additional sources of financing. The Ministry of Health expected the plan to reduce the outstanding liabilities of autonomous public healthcare centres by about PLN 2,900 million (Uchwała nr 58/2009 Rady Ministrów).

The Medical Service Law also provides for a mechanism to support the founding bodies operating the autonomous public healthcare centres heavily in debt. Article 190 of the Medical Service Law provides that a founding body that transformed its autonomous public healthcare centre into a commercial company before 31 December 2013 shall have a significant part of the liabilities taken over from such autonomous public healthcare centre, and calculated as on 31 December 2009, written off. The list of liability types eligible for such a write-off, as set forth in Articles 191, 192 and 194 of the Medical Service Law includes e.g. tax and customs duties liabilities as well as a portion of social security contributions withholdings and of the fees and penalties related to environmental impact. Under Article 197 of the said Law, by 31 December 2013 such a founding body may also apply for a special-purpose subsidy from the State Treasury to cover a portion of the civil-law liabilities taken over from the transformed autonomous public healthcare centre. The total amount budgeted for such subsidies is PLN 1,400 million.

4. THE DESIRABLE CHANGES IN THE OPERATING PRINCIPLES OF HEALTHCARE SERVICE PROVIDERS

The desirable systemic solution is the transformation of all hospitals into commercial companies. Such a solution would eliminate the majority of the barriers identified in the structure of autonomous public healthcare centre. This covers the ongoing management, the owner's supervision opportunities and the availability of a wider range of financial instruments. In this way the healthcare service providers would also be subjected to the regulations concerning, e.g. bankruptcy, which would present an obstacle against the

uncontrolled accumulation of debt. At the same time, this would eliminate the risk of the owner's becoming liable for the debt generated by healthcare service providers. The owners would acquire the instruments for the effective control of the way their assets are managed, for instance through the supervisory boards.[2] This solution would also make it impossible for entities other than those financially engaged in the establishment of healthcare service providers to influence their operations; this would be achieved by the liquidation of social councils. The popularization of the provision of healthcare services within the formula of a commercial company would also facilitate a desirable change in their business partners' expectations towards collection of their dues. The current belief that healthcare industry payees will certainly obtain their financing despite any delays would have to give way to the awareness that a healthcare service provider may go bankrupt. This would put the healthcare service providers under stiff budget constraints, provided that government is under a binding obligation not to assist the establishments facing the threat of insolvency and bankruptcy.

The formula of a commercial company also offers medical service providers, especially hospitals, the chance to get additional financing. This is particularly important when faced with the need for significant investments in healthcare infrastructure. This results from the necessity of adapting the healthcare facilities network to the changing map of population density (movement into large cities at the expense of smaller localities; Kancelaria Prezesa Rady Ministrów, 2010), from the change in patient cohort composition which results from demographic and epidemiological shifts (the ageing society, increased demand for long-term care), and finally from the need to modernize the existing infrastructure.

The natural profit orientation of commercial companies and the prospect of insolvency for those who do not manage to earn enough income to cover expenses may facilitate the restructuring of the Polish healthcare industry. When compared to the developed countries, Poland has a large number of acute care beds per 1,000 population but their occupancy is rather poor (Table 7). These problems contribute to the healthcare providers' significant level of debt.

Transforming autonomous public healthcare centres into commercial companies may also bring about some adverse effects. Those worth

[2] It should also be noted that members of supervisory boards and management boards of commercial companies are subject to penal and civil proceedings for any gross negligence in performing their duties, e.g. for not filing for company bankruptcy in due time.

mentioning here include first of all the company's obligation to pay corporate income tax – even if such a company is a medical service provider. The provision of Medical Service Law stating that on the effective transformation date the employees of the transformed autonomous public healthcare centre shall become the employees of the successor company might also bring adverse effects, as this will make restructuring the operations of such companies difficult.

Incorporation in the legal form of a commercial company eliminates most of the dysfunctions inherent to the legal form of autonomous public healthcare centres. However, the transformation itself will not magically improve the functioning of hospitals. The very change in legal form is unlikely to solve the problem without a parallel restructuring aimed at adjusting expenditure to the income earned. A 2011 survey of 37 hospitals operating as commercial companies owned by the respective local authorities demonstrated that 27 of them earned profits but 10 recorded losses. The median net profitability rate for the whole group was 1.1%. This is a better average result than that reached by autonomous public healthcare centres – and this is despite the income tax cost, annually amounting to nearly PLN 200,000 per company (Wójcik, 2011). While it is true that the financial position of hospitals operating as commercial companies is much varied, there is no denying that such a formula prevents negligence from both company managers and shareholders (local authorities).

5. FINANCIAL INSTABILITY OF AUTONOMOUS PUBLIC HEALTHCARE CENTRES – CONSEQUENCES FOR THEIR FOUNDING BODIES

Now in Poland we have 18,598 medical service providers (Table 1). The huge majority of them are outpatient clinics (17,862), most of whom (16,171) are non-public. There are only 1,688 medical service providers in Poland who are publicly-owned outpatient facilities. Medical services are also provided by 736 hospitals, among which as many as 578 are public facilities. Out of 155 non-public hospitals, as many as 117 are owned by commercial companies originating from a transformation of the hospitals previously operating as autonomous public healthcare centres. The majority of such transformations took place during 2008-2010, when liquidation of autonomous public healthcare centres led to the formation of 62 hospitals operating as commercial companies, i.e. either private or public limited

companies (Table 2). Geographically, the majority of hospital transformations from autonomous public healthcare centres into commercial companies so far has taken place in the provinces of Dolnośląskie [Lower Silesia], Śląskie [Silesia] and Kujawsko-Pomorskie. These three provinces saw as many as 54 hospital transformations out of the total of 114 executed during 2000-2010.

The overall level of debt incurred by autonomous public healthcare centres significantly increased during 2001-2011. At the end of June 2001, the total debt amount was PLN 2,278.9 million, while at the end of September 2011 – PLN 5,077.3 million. Against the expectations of the Ministry of Health, during the implementation period of the multi-year Action Plan of '*Supporting the local authorities in their actions aimed at stabilizing the public healthcare system*' (the so-called Plan B), the debt level of autonomous public healthcare centres went down only slightly – from PLN 5,808.7 million at the end of December 2008 to PLN 5,077.3 million at the end of September 2011.

However, a positive phenomenon was also observed during the 2002-2011 period – a visible decrease in mature liabilities in the structure of amounts owed by autonomous public healthcare centres. At the close of 2002, mature liabilities made up 97.83% of the total debt of the autonomous public healthcare centres owned by central government and 90.48% of those owned by the local authorities. At the close of 2008, those proportions went down to 76.03% and 32.77% respectively. This proves both the significant progress in debt restructuring of medical service providers and their improved financial planning during that period. Unfortunately, since 2009 we have again seen an increase in the mature liabilities share in the amounts owed by autonomous public healthcare centres.

A major part of the total debt of autonomous public healthcare centres is owned by the entities whose founding bodies are the district and provincial authorities (Table 4). At the end of 2010, a huge part of the total debt of autonomous public healthcare centres owned by provincial authorities was distributed between the provinces of Mazowieckie (19.43%), Lubuskie (11.38%), Lubelskie (10.80%), Śląskie (10.03%) and Dolnośląskie (7.11%). At the same time, the largest share in the total debt of district-owned autonomous public healthcare centres belonged to the districts located within the provinces of Dolnośląskie (12.43%), Lubelskie (12.19%), Łódzkie (12,03%) and Mazowieckie (10.40%) (Table 5).

In many cases, the level of debt accumulated by autonomous public healthcare centres exceeded the repayment capacity of their founding bodies. The district and provincial authorities, who are the founding bodies of most

hospitals, are subject to strict regulations on acceptable debt levels. Therefore many local authorities and the hospitals operated by them were ineligible to the public aid offered under the Action Plan of '*Supporting the local authorities in their actions aimed at stabilizing the public healthcare system*'. The Action Plan assumed the liquidation of autonomous public healthcare centres, with their debt to be taken over by their founding bodies. Only then could the local authorities involved obtain subsidies equivalent in volume to the public-law liabilities taken over. Even if a huge portion of such debt was covered by public aid, the public-law liabilities taken over would count towards the total debt levels incurred by the local authorities. This might have put them in breach of the regulations on acceptable debt levels. Moreover, the time of taking over the liabilities was not synchronized with the time of subsidy availability – the difference may have been measurable in months, when the local authorities would have to suffer the consequences of going beyond the acceptable debt threshold as a result of taking over the liabilities of their autonomous public healthcare centre. From this point of view, the transformation procedure provided for in the Medical Service Law is less burdensome for the local authorities as it allows the transformation of autonomous public healthcare centres into commercial companies without prior liquidation and with the local authority taking over only some of the debt accumulated by the entity under transformation.

The level of debt accumulated by the autonomous public healthcare centres constitutes a major problem for both district and provincial authorities. This is confirmed by a look at the debt-to-income ratio of the local authorities, their debt-to-income ratio calculated against the total of their own debt and the debt taken over from their autonomous public healthcare centres, and finally the ratio of the debt accumulated by the autonomous public healthcare centres to the income of their founding local authorities (Table 6).

At the end of 2010, the average debt-to-income ratio of the provincial authorities was 30.43%, and as much as 43.96% when calculated against the sum of their own debt and the debt taken over. Only for two provinces (Mazowieckie and Opolskie) did the debt-to-income ratio exceed 40%. However, with the total of their own debt and the debt taken over from their autonomous public healthcare centres taken into account, the provincial authorities' debt-to-income ratio exceeds 40% in as many as a half of all the provinces. The proportion of the debt accumulated by autonomous public healthcare centres run by provincial authorities to the income earned by the respective provincial authorities is the highest in the provinces of Lubuskie (45.76%), Podlaskie (31.79%), Pomorskie (25,39%) and Lubelskie (27,38%).

At the end of 2010, the average debt-to-income ratio of the district authorities was 24.16%, growing to 31.29% when calculated against the sum of their own debt and the debt taken over. With the total of their own debt and the debt taken over from their autonomous public healthcare centres taken into account, the district authorities' debt-to-income ratio is the highest for the districts located within the provinces of Lubuskie (60.69%) and Dolnośląskie (44.27%). Only for 44 out of the total number of 314 Polish districts does the debt-to-income ratio exceed 40%. However, with the total of their own debt and the debt taken over from their autonomous public healthcare centres taken into account, the district authorities' debt-to-income ratio exceeds 40% in as many as 93 districts. However, with the total of their own debt and the debt taken over from their autonomous public healthcare centres taken into account, the district authorities' debt-to-income ratio exceeds 4 in as many as 100 % of districts. The proportion of the debt accumulated by autonomous public healthcare centres run by district authorities to the income earned by the respective districts is the highest in the provinces of Lubuskie (17.8%), Lubelskie (13.55%), Łódzkie (12.89%) and Dolnośląskie (10.42%).

6. CONCLUSIONS

A soft budget constraint is a very specific social institution. It consists in the existence of the entrenched, universal expectations of the participants to a social interaction that one party to a commercial or social contract will be disposed to directly or indirectly cover the financial shortages of the other party. Such soft budget constraints may be among the major causes of the mass insolvencies in various entities, including the local authorities and the units operated by them.

The legal and organizational framework of an autonomous public healthcare centre is a classic example of an entity exposed to soft budget constraints. The aforementioned analysis proved these type of constraints to produce a specific industry belief that an autonomous public healthcare centre may not cover its own liabilities. This creates a flaw which naturally wastes a large part of the efforts and energy spent on increasing the entity's efficiency. The enormous inertia has its tangible financial dimension, visible in multi-billion, systemic debt. The time spent waiting for the elimination of this dysfunction has proved wasted. The lack of a systemic solution gave rise to individual initiatives, making use of the existing, but highly complicated legal opportunities. At the end of 2011, in Poland there were over 71

hospitals operating as municipal companies. They performed quite well in the difficult market for healthcare services. Those innovations generally confirm the possibility of the effective elimination of the dysfunctions described here through a transformation of the business formula of healthcare service provision into one, subject to hard budget constraints.

Table 1

Number of medical service providers in Poland as of 30.04.2011

Medical service providers	Hospitals	Outpatient facilities	Total
Countrywide total, of which:	736	17,862	18,598
Non-public facilities, of which:	155	16,171	16,326
autonomous public healthcare centres transformed into commercial companies by the local authorities	117	312	429
Public facilities	578	1,688	2,266

Source: *Przekształcenia w ochronie zdrowia* (2011), pp. 2-3

Table 2

Number of hospitals transformed into non-public entities

Specification	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Countrywide total, of which by province:	2	6	8	5	14	5	3	9	19	21	22	114
Dolnośląskie	0	0	5	2	6	1	1	0	8	0	1	24
Kujawsko-pomorskie	0	3	1	0	2	2	0	1	1	1	1	12
Lubelskie	0	0	0	0	1	1	0	0	0	0	0	2
Lubuskie	0	1	1	0	0	0	1	2	0	2	2	9
Łódzkie	0	0	0	0	0	0	0	0	1	2	2	5
Małopolskie	0	0	0	1	0	0	0	1	2	1	1	6
Mazowieckie	0	0	0	0	0	0	0	1	0	0	4	5
Opolskie	0	0	0	0	3	1	0	0	0	2	0	6
Podkarpackie	0	0	0	0	0	0	0	0	0	1	0	1
Podlaskie	0	0	1	0	0	0	0	0	0	0	0	1
Pomorskie	0	1	0	0	0	0	0	1	2	3	1	8
Śląskie	0	0	0	0	1	0	0	3	0	7	7	18
Świętokrzyskie	0	0	0	0	0	0	1	0	1	0	0	2
Warmińsko-mazurskie	1	1	0	1	1	0	0	0	0	1	0	5
Wielkopolskie	1	0	0	1	0	0	0	0	2	1	2	7
Zachodnio pomorskie	0	0	0	0	0	0	0	0	2	0	1	3

Source: *Przekształcenia w ochronie zdrowia* (2011), p. 23

Table 3

Debt accumulated by autonomous public healthcare centres during the 2001-2011 period

As of end of	State-owned autonomous public healthcare centres			Autonomous public healthcare centres owned by local authorities			Autonomous public healthcare centres total		
	Total debt [millions PLN]	Mature debt [millions PLN]	Mature-to-total debt ratio	Total debt [millions PLN]	Mature debt [millions PLN]	Mature-to-total debt ratio	Total debt [millions PLN]	Mature debt [millions PLN]	Mature-to-total debt ratio
Jun 2001	397.2	no data avail.	no data avail.	1,881.7	no data	no data	2,278.9	no data	no data
Dec 2001	476.1	no data avail.	no data avail.	2,464.5	no data avail.	no data avail.	2,940.6	no data avail.	no data avail.
Mar 2002	526.6	no data avail.	no data avail.	2,335.2	no data avail.	no data avail.	2,861.8	no data avail.	no data avail.
Jun 2002	576.3	no data avail.	no data avail.	2,560.8	no data avail.	no data avail.	3,137.1	no data avail.	no data avail.
Sept 2002	554.0	no data avail.	no data avail.	2,655.5	no data avail.	no data avail.	3,209.5	no data avail.	no data avail.
Dec 2002	543.7	531.9	97.83%	3,002.9	2,716.9	90.48%	3,546.6	3,248.8	91.60%
Mar 2003	625.0	no data avail.	no data avail.	3,974.8	no data avail.	no data avail.	4,599.8	no data avail.	no data avail.
Jun 2003	680.2	no data avail.	no data avail.	3,753.3	no data avail.	no data avail.	4,433.5	no data avail.	no data avail.
Sept 2003	694.8	no data avail.	no data avail.	4,256.7	no data avail.	no data avail.	4,951.5	no data avail.	no data avail.
Dec 2003	722.7	710.2	98.27%	4,416.2	4,022.8	91.09%	5,138.9	4,733.0	92.10%
Mar 2004	809.5	no data avail.	no data avail.	4,782.9	no data avail.	no data avail.	5,592.4	no data avail.	no data avail.
Jun 2004	927.3	no data avail.	no data avail.	5,020.4	no data avail.	no data avail.	5,947.7	no data avail.	no data avail.
Sept 2004	956.0	no data avail.	no data avail.	5,222.2	no data avail.	no data avail.	6,178.2	no data avail.	no data avail.
Dec 2004	938.1	923.8	98.48%	5,233.7	4,760.6	90.96%	6,171.8	5,684.4	92.10%
Mar 2005	950.7	no data avail.	no data avail.	5,438.7	no data avail.	no data avail.	6,389.4	no data avail.	no data avail.
Jun 2005	993.2	no data avail.	no data avail.	5,625.7	no data avail.	no data avail.	6,618.9	no data avail.	no data avail.
Sept 2005	1,040.5	no data avail.	no data avail.	5,638.8	no data avail.	no data avail.	6,679.3	no data avail.	no data avail.
Dec 2005	955.3	825.7	86.43%	5,793.5	4,049.7	69.90%	6,748.8	4,875.4	72.24%
Mar 2006	1,007.0	no data avail.	no data avail.	5,731.9	no data avail.	no data avail.	6,738.9	no data avail.	no data avail.
Jun 2006	1,085.6	no data avail.	no data avail.	5,689.6	no data avail.	no data avail.	6,775.2	no data avail.	no data avail.
Sept 2006	1,149.1	no data avail.	no data avail.	5,749.8	no data avail.	no data avail.	6,898.9	no data avail.	no data avail.
Dec 2006	1,151.0	917.0	79.67%	5,635.2	2,686.7	47.68%	6,786.2	3,603.7	53.10%
Mar 2007	1,143.6	no data avail.	no data avail.	5,618.5	no data avail.	no data avail.	6,762.1	no data avail.	no data avail.

As of end of	State-owned autonomous public healthcare centres			Autonomous public healthcare centres owned by local authorities			Autonomous public healthcare centres total		
	Total debt [millions PLN]	Mature debt [millions PLN]	Mature-to-total debt ratio	Total debt [millions PLN]	Mature debt [millions PLN]	Mature-to-total debt ratio	Total debt [millions PLN]	Mature debt [millions PLN]	Mature-to-total debt ratio
Jun 2007	1,100.3	no data avail.	no data avail.	5,842.1	no data avail.	no data avail.	6,942.4	no data avail.	no data avail.
Sept 2007	1,076.1	no data avail.	no data avail.	5,441.0	no data avail.	no data avail.	6,517.1	no data avail.	no data avail.
Dec 2007	1,048.6	797.3	76.03%	4,871.8	1,830.1	37.57%	5,920.4	2,627.4	44.38%
Mar 2008	1,142.2	no data avail.	no data avail.	4,955.1	no data avail.	no data avail.	6,097.3	no data avail.	no data avail.
Jun 2008	1,095.9	no data avail.	no data avail.	4,976.2	no data avail.	no data avail.	6,072.1	no data avail.	no data avail.
Sept 2008	921.4	no data avail.	no data avail.	5,049.5	no data avail.	no data avail.	5,970.9	no data avail.	no data avail.
Dec 2008	1,131.8	847.0	74.84%	4,676.9	1,532.6	32.77%	5,808.7	2,379.6	40.97%
Mar 2009	1,141.0	no data avail.	no data avail.	4,683.0	no data avail.	no data avail.	5,824.0	no data avail.	no data avail.
Jun 2009	1,019.7	no data avail.	no data avail.	4,644.0	no data avail.	no data avail.	5,663.7	no data avail.	no data avail.
Sept 2009	930.3	no data avail.	no data avail.	4,582.3	no data avail.	no data avail.	5,512.6	no data avail.	no data avail.
Dec 2009	902.8	693.9	76.86%	4,426.1	1,646.8	37.21%	5,328.9	2,340.8	43.93%
Mar 2010	935.3	742.9	79.43%	4,520.2	1,763.7	39.02%	5,455.5	2,506.6	45.95%
Jun 2010	939.6	750.2	79.84%	4,619.9	1,859.7	40.25%	5,559.5	2,610.0	46.95%
Sept 2010	979.2	733.8	74.94%	4,551.1	1,833.7	40.29%	5,530.3	2,567.5	46.43%
Dec 2010	977.3	646.0	66.10%	4,202.2	1,612.8	38.38%	5,179.5	2,258.8	43.61%
Mar 2011	972.9	677.8	69.67%	4,195.9	1,702.3	40.57%	5,168.8	2,380.0	46.05%
Jun 2011	987.6	639.2	64.72%	4,354.8	1,814.7	41.67%	5,342.4	2,454.0	45.93%
Sept 2011	1,010.6	711.9	70.44%	4,066.7	1,682.7	41.38%	5,077.3	2,394.6	47.16%

Source: Data of the Ministry of Health

Table 4

Geographical distribution of debt accumulated by the autonomous public healthcare centres owned by local authorities

Specification	Debt of autonomous public healthcare centres owned by local authorities [PLN]		Debt of autonomous public healthcare centres supervised by provincial authorities [PLN]		Debt of autonomous public healthcare centres supervised by the capital city of Warsaw [PLN]	
	2009	2010	2009	2010	2009	2010
Countrywide total, of which by province:	4,438,686,863	4,185,329,505	2,003,832,580	1,908,300,681	177,962,964	200,172,683
Dolnośląskie	481,602,277	354,432,240	195,767,952	135,692,882	0	0
Kujawsko-pomorskie	86,698,951	61,955,446	23,101,881	17,088,025	0	0
Lubelskie	392,118,915	401,746,451	213,825,625	206,017,954	0	0
Lubuskie	414,008,586	339,065,020	223,937,314	217,259,455	0	0
Łódzkie	469,789,439	444,111,558	135,123,251	117,031,419	0	0
Małopolskie	218,141,873	194,407,085	84,572,207	52,590,622	0	0
Mazowieckie	712,070,785	746,443,423	342,452,325	370,689,211	177,962,964	200,172,683
Opolskie	45,846,465	38,130,247	5,275,682	4,672,622	0	0
Podkarpackie	157,993,110	201,128,231	102,368,348	125,956,234	0	0
Podlaskie	169,618,906	192,836,347	122,145,088	140,591,779	0	0
Pomorskie	310,400,700	214,833,196	215,043,485	183,912,055	0	0
Śląskie	487,098,529	481,935,974	222,600,898	191,313,075	0	0
Świętokrzyskie	140,527,237	162,682,253	51,313,784	69,550,987	0	0
Warmińsko-mazurskie	88,792,945	82,879,006	2,601,621	4,666,274	0	0
Wielkopolskie	167,935,098	181,545,286	52,269,727	61,431,763	0	0
Zachodniopomorskie	96,043,047	87,197,741	11,433,392	9,836,325	0	0

Specification	Debt of autonomous public healthcare centres supervised by cities with district rights [PLN]		Debt of autonomous public healthcare centres supervised by district authorities [PLN]		Debt of autonomous public healthcare centres supervised by commune (*gmina*) authorities [PLN]	
	2009	2010	2009	2010	2009	2010
Countrywide total, of which by province:	332,715,129	334,773,969	1,779,436,307	1,603,172,663	144,739,883	138,909,509
Dolnośląskie	2,418	3,838	266,190,431	198,495,359	19,641,476	20,240,162
Kujawsko-pomorskie	38,512,096	38,923,132	25,041,696	5,890,712	43,278	53,576
Lubelskie	0	0	178,038,472	195,359,754	254,818	368,742
Lubuskie	0	0	189,385,153	121,805,565	686,119	,
Łódzkie	38,337,293	23,692,425	189,078,187	192,941,095	107,250,708	110,446,620
Małopolskie	48,232,303	46,705,924	84,050,301	94,123,649	1,287,062	986,890
Mazowieckie	13,283,235	8,291,937	177,581,220	166,653,642	791,041	635,951
Opolskie	0	0	40,569,140	33,453,464	1,643	4,162
Podkarpackie	170,761	112,274	55,251,262	74,343,218	202,739	716,505
Podlaskie	248,025	339,757	38,761,322	51,323,234	8,464,471	581,578
Pomorskie	104,076	170	95,184,244	30,888,063	68,895	32,908
Śląskie	165,276,035	178,528,242	99,110,333	111,503,099	111,263	591,557
Świętokrzyskie	,	,	88,504,798	92,310,682	708,655	820,584
Warmińsko-mazurskie	8,242,291	7,554,728	74,244,814	68,392,231	3,704,219	2,265,774
Wielkopolskie	13,171,475	21,276,651	102,478,896	98,821,872	15,000	15,000
Zachodniopomorskie	7,135,121	9,344,891	75,966,038	66,867,025	1,508,496	1,149,501

Source: Data of the National Council of Regional Audit Chambers

Table 5

Geographical distribution of debt accumulated by the autonomous public healthcare centres owned by local authorities

Specification	Debt of autonomous public healthcare centres owned by local authorities		Debt of autonomous public healthcare centres supervised by provincial authorities		Debt of autonomous public healthcare centres supervised by the capital city of Warsaw		Debt of autonomous public healthcare centres supervised by cities with district rights		Debt of autonomous public healthcare centres supervised by district authorities		Debt of autonomous public healthcare centres supervised by commune (gmina) authorities	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Dolnośląskie	10.85%	8.47%	9.77%	7.11%	0.00%	0.00%	0.00%	0.00%	14.96%	12.38%	13.57%	14.57%
Kujawsko-pomorskie	1.95%	1.48%	1.15%	0.90%	0.00%	0.00%	11.58%	11.63%	1.41%	0.37%	0.03%	0.04%
Lubelskie	8.83%	9.60%	10.67%	10.80%	0.00%	0.00%	0.00%	0.00%	10.01%	12.19%	0.18%	0.27%
Lubuskie	9.33%	8.10%	11.18%	11.38%	0.00%	0.00%	0.00%	0.00%	10.64%	7.60%	0.47%	0.00%
Łódzkie	10.58%	10.61%	6.74%	6.13%	0.00%	0.00%	11.52%	7.08%	10.63%	12.03%	74.10%	79.51%
Małopolskie	4.91%	4.64%	4.22%	2.76%	0.00%	0.00%	14.50%	13.95%	4.72%	5.87%	0.89%	0.71%
Mazowieckie	16.04%	17.83%	17.09%	19.43%	100.00%	100.00%	3.99%	2.48%	9.98%	10.40%	0.55%	0.46%
Opolskie	1.03%	0.91%	0.26%	0.24%	0.00%	0.00%	0.00%	0.00%	2.28%	2.09%	0.00%	0.00%
Podkarpackie	3.56%	4.81%	5.11%	6.60%	0.00%	0.00%	0.05%	0.03%	3.10%	4.64%	0.14%	0.52%
Podlaskie	3.82%	4.61%	6.10%	7.37%	0.00%	0.00%	0.07%	0.10%	2.18%	3.20%	5.85%	0.42%
Pomorskie	6.99%	5.13%	10.73%	9.64%	0.00%	0.00%	0.03%	0.00%	5.35%	1.93%	0.05%	0.02%
Śląskie	10.97%	11.51%	11.11%	10.03%	0.00%	0.00%	49.67%	53.33%	5.57%	6.96%	0.08%	0.43%
Świętokrzyskie	3.17%	3.89%	2.56%	3.64%	0.00%	0.00%	0.00%	0.00%	4.97%	5.76%	0.49%	0.59%
Warmińsko-mazurskie	2.00%	1.98%	0.13%	0.24%	0.00%	0.00%	2.48%	2.26%	4.17%	4.27%	2.56%	1.63%
Wielkopolskie	3.78%	4.34%	2.61%	3.22%	0.00%	0.00%	3.96%	6.36%	5.76%	6.16%	0.01%	0.01%
Zachodnio-pomorskie	2.16%	2.08%	0.57%	0.52%	0.00%	0.00%	2.14%	2.79%	4.27%	4.17%	1.04%	0.83%

Source: Data of the National Council of Regional Audit Chambers

Table 6

Distribution of the autonomous public healthcare centres (APHCs) debt burden among individual provinces and districts (LAs) as of 31.12.2010

Province	LA debt-to income ratio	Ratio of LA debt increased by APHCs debt to LA income	Ratio of APHCs debt to the supervising LA income
Provincial authorities	30.43%	43.96%	13.53%
Dolnośląskie	24.01%	37.40%	13.39%
Kujawsko-Pomorskie	38.37%	40.45%	2.08%
Lubelskie	31.92%	59.30%	27.38%
Lubuskie	36.47%	82.18%	45.71%
Łódzkie	31.31%	46.23%	14.92%
Małopolskie	33.50%	38.38%	4.88%
Mazowieckie	57.02%	72.13%	15.11%
Opolskie	47.78%	48.73%	0.95%
Podkarpackie	26.25%	40.45%	14.20%
Podlaskie	3.47%	35.26%	31.79%
Pomorskie	37.12%	62.51%	25.39%
Śląskie	12.98%	27.27%	14.29%
Świętokrzyskie	0.00%	13.36%	13.36%
Warmińsko-Mazurskie	30.19%	31.09%	0.90%
Wielkopolskie	7.17%	12.95%	5.78%
Zachodniopomorskie	20.91%	22.25%	1.34%
District authorities by province	24.16%	31.29%	7.13%
Dolnośląskie	33.85%	44.27%	10.42%
Kujawsko-Pomorskie	21.15%	21.67%	0.52%
Lubelskie	22.16%	35.71%	13.55%
Lubuskie	42.89%	60.69%	17.80%
Łódzkie	18.22%	31.11%	12.89%
Małopolskie	26.69%	31.60%	4.91%
Mazowieckie	22.65%	28.94%	6.29%
Opolskie	20.76%	25.36%	4.60%
Podkarpackie	19.39%	24.03%	4.64%
Podlaskie	12.76%	20.61%	7.85%
Pomorskie	25.44%	27.86%	2.42%
Śląskie	22.09%	29.41%	7.32%
Świętokrzyskie	22.35%	31.55%	9.20%
Warmińsko-Mazurskie	26.58%	32.24%	5.66%
Wielkopolskie	23.21%	27.94%	4.73%
Zachodniopomorskie	26.81%	32.56%	5.75%

Source: Data of the National Council of Regional Audit Chambers

Table 7

Acute care beds data for selected OECD countries

Country	Number of acute care beds per 1,000 population	Acute care beds occupancy level
Japan	13.7	75.3%
South Korea	9.3	71.6% (3)
Germany	8.2	76.2%
Austria	7.7	79.0%
Czech Republic	7.1	75.3%
Hungary	7.1	74.3%
Poland	6.7	71.8% (1)
France	6.6	74.4%
Belgium	6.5	74.0%
Slovakia	6.5	67.3%
Finland	6.2	no data avail.
Iceland	5.8	no data avail.
Luxembourg	5.5	74.2%
Estonia	5.4	67.7%
Switzerland	5.1	87.9%
OECD-27	4.9	76.1%
Ireland	4.9	89.2%
Greece	4.8	75.4%
Netherlands	4.7	52.7%
Slovenia	4.6	71.2%
Australia	3.8	no data avail.
Italy	3.7	79.5%
Denmark	3.5	84.0% (2)
Israel	3.5	96.3%
Canada	3.3	93.0%
Norway	3.3	91.6%
Portugal	3.3	72.1%
UK	3.3	84.2%
Spain	3.2	77.6%
USA	3.1	66.5%
Sweden	2.8	no data avail.
Turkey	2.5	62.3%
Chile	2.3	76.6%
Mexico	1.7	63.4%

(1) Data of the Ministry of Health
(2) As of 2002
(3) As of 2003

Source: OECD (2011), p. 85

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Received: March 2010, revised: February 2012