Case file no. I ACa 1/04
JUDGMENT
IN THE NAME OF THE REPUBLIC OF POLAND
29 June 2004

The Appellate Court in Warsaw, 1st Civil Division sitting in the panel:
Krzysztof Strzelczyk – Presiding Judge, Judge of the Appellate Court
Anna Owczarek – Judge of the Appellate Court
Hanna Wawrzyniak – Judge of the Circuit Court (delegated)
Janusz Bielski – Reporting clerk

upon hearing on 29 June 2004 in Warsaw of the case brought to court by Healthcare Institution in Ż. against the National Healthcare Fund (Mazowiecki Voivodeship Branch) with its seat in Warsaw
for payment
as a result of the defendant's appeal
against the judgment of the Circuit Court in Warsaw
of 11 September 2003,
case file no. I C 1126/02

1. Amends the appealed judgment in its part encompassing point 1 by dismissing the action and in its part encompassing point 3 by ordering the Healthcare Institution in Ż. to pay the National Healthcare Fund, Mazowiecki Voivodeship Branch, an amount of PLN 6 000 as reimbursement of legal representation costs.
2. Orders the Healthcare Institution in Ż. to pay the National Healthcare Fund an amount of PLN 5 400 as reimbursement of legal representation costs in the Second Instance.
3. Waives the appeal filing fee for the complainant.

STATEMENT OF REASONS

The Circuit Court in Warsaw, by its judgment of 11 September 2003 in the case brought to court by the Healthcare Institution in Ż. against the National Health Fund, Mazowiecki Voivodeship Branch, for the payment of PLN 1 247 330.93 with statutory interest accruing from 1 April 2000 until the date of payment, ordered the entire amount requested in the action to be paid to the plaintiff with statutory interest accruing until 6 September 2002, dismissed the action in its remaining scope and ordered the due court costs to be paid to the plaintiff.

The Court established that on […] December 1998, the Healthcare Institution in Ż. and the Mazowiecki Regional Health Fund entered into a contract on provision of basic healthcare benefits. On the same date the following contracts were also entered into: for the provision of specialised outpatient healthcare benefits and for the provision of inpatient healthcare benefits within the public health insurance system. Additionally, the contract also bound the parties for the provision of dental benefits. On […] February 1999, the parties also entered into a contract on the rules of terms and conditions governing emergency healthcare benefits provided to patients covered by the public healthcare insurance for the year 1999. Prior to entering into any of these contracts with the Health Fund, a tender was called for healthcare providers. The Health Fund imposed the price rates for each consultation, to which the plaintiff agreed out of fear that if he failed to accept the rates, the Health Fund would withdraw from the contract. The year 1999 was the first year of functioning of the Health Funds and both parties to the concluded contracts had difficulties estimating the number of benefits to be provided by the healthcare providers. The contracts with the defendant were entered into for a period of one year. In these contracts, the parties reserved the right to renegotiate the financial conditions of the healthcare benefits and other terms and conditions after the first quarter of 1999. The negotiations with the Healthcare Institution in Ż. never took place. It is an undisputed fact between the parties that the plaintiff provided more benefits than the conditions of

the contracts stipulated. On […] December 2001, the plaintiff issued invoices for the over-the-limit inpatient healthcare benefits provided in 1999 amounting to PLN 930 880.76, for the over-the-limit specialised (hospital) healthcare benefits amounting to PLN 258 860.62, for the over-the-limit dental benefits amounting to PLN 8 612.95 and for the over-the-limit emergency healthcare benefits amounting to PLN 48 976.60. The invoice on over-the-limit emergency healthcare benefits was sent back by the Health Fund along with a statement to the effect that it was inconsistent with the contract entered into by the parties. In 2001 and 2002, the parties exchanged correspondence regarding the payment for over-the-limit healthcare benefits provided in 1999 exceeding the quantitative limits stipulated in contracts entered into by the Healthcare Institution. These amounts were not paid by the Health Fund.

The Circuit Court established that, at least in the first half of 1999, there was no possibility of moving the financial means designated for the performance of individual contracts. The healthcare providers received money in monthly installments: 80% in the given month and 20% by the 25th day of the following month. The performance of contracts was settled on a quarterly basis, hence, if the Healthcare Institution failed to provide the number of contracted benefits, it would have received payment for the actually provided benefits and, in the event of providing over-the-limit benefits, it received the payment only for the contracted number of benefits. The Circuit Court also assumed that in the second half of 1999 the contracts were renegotiated, despite the lack of appropriate documents to confirm this. In the opinion of the Court of First Instance, the circumstances of the case allow to assume that this issue is deemed to be proved. Since in the first half of 1999, the over-the-limit benefits were provided by almost all Healthcare Institutions, the Mazowiecki Regional Health Fund paid the Healthcare Institutions which had entered into contracts with it the equivalent of 40% of the value of over-the-limit healthcare benefits. The remaining amounts were not paid to any of these Institutions due to lack of financial means at the Health Fund. Based on its findings and pursuant to provisions of law related to intervening in the another's affairs without a mandate on its findings, namely Art. 752-757 of the Civil Code of Poland, the Circuit Court ruled the request of the action justified. In the opinion of the Circuit Court the Act of 6 February 1997 introduced universal obligatory health insurance and pursuant to Art. 3 and 4 of the Act on Universal Health Insurance the Health Fund was charged with the duty to carry out the obligations arising from the social insurance. The Health Fund, in performance of these obligations, should enter into contracts with healthcare providers. However, in the opinion of the Court, it was not the only form of transferring financial means for medical purposes. The contracts entered into by the Health Funds with healthcare providers for 1999 diverged significantly from the actual needs, both overestimating and underestimating them. In the opinion of the Circuit Court, the parties foresaw the impossibility of establishing the number of benefits to be provided by the plaintiff, as §5 of the Contract of 31 December 1998 for the provision of medical services related to basic healthcare benefits did not introduce limits on the number of benefits. Such limit resulted only from the established amount of financial means and the negotiated rate for one consultation. The Circuit Court emphasized that the defendant did not question its duties as an entity to provide benefits under the universal health insurance, as in the first quarter of 1999 it paid to all the entities providing healthcare benefits financial means in excess of the limits stipulated in the contracts, amounting to 40% of their value. For this reason, in the opinion of the Circuit Court, the plaintiff, by providing benefits in excess of the contracted limits was intervening in "another's" affairs, that is: provided consultations and healthcare benefits or, in other words, performed the statutory obligations of the defendant. Due to the above, the plaintiff is justified in his request for the reimbursement of warranted expenses and costs with statutory interest. Therefore, it is the opinion of the Court of First Instance that the plaintiff's request for the reimbursement of incurred costs of treatments is justified. The Circuit Court found it irrelevant for the case that the plaintiff did not submit a material substantiation of the fact that he provided benefits in excess of the contracted limits, which was the condition for increasing the amount of installments as, independently of whether such a substantiation had been presented, the increased installment could not have been transferred to the Healthcare Institution due to lack of funds at the Health Fund. Moreover, these

issues must be resolved with consideration for the patients' interests, as the Constitution of the Republic of Poland guarantees the right to protection of health to all its citizens. If the position of the defendant is accepted, this would allow the inference that a hospital or any other healthcare institution may refuse medical assistance even in life-threatening situations for the mere reason of not having a contract signed for such benefits.

The Circuit Court observed that the amount of costs incurred by the plaintiff is evidenced in the presented invoices and the defendant did not question this amount at any stage of the proceedings. The defendant only claimed that there were no legal grounds for the payment of installments for over-the-limit benefits. The defendant did not question the veracity of the plaintiff's submissions regarding the number of provided benefits. Therefore, the Circuit Court found that the requested amount has been accepted by the defendant and requires no further proof besides the presented invoices. In the opinion of the Circuit Court, the claim became due on the date of service of the writ of summons and so the interest has been accruing since that date. The defendant appealed this judgment, alleging that:

I. The judgment breaches substantive law by:

1) an erroneous interpretation and incorrect application of Art. 752 and subsequent of the Civil Code resulting from the assumption that, pursuant to provisions on intervening in another's affairs without a mandate, the plaintiff is entitled to request that the defendant pay for healthcare benefits provided without a legal basis,

2) failure to address and consequently, an erroneous interpretation of the Act of 6 February 1997 on Universal Health Insurance and, in particular, its Art. 4(2) and (3), Art. 53(3) and Art. 54(4).

3) failure to address and consequently, an erroneous interpretation of Art. 19 of the Act of 30 August 1991 on Healthcare Institutions.

4) failure to address the provisions of the contracts binding the parties and entered into on the basis of the Act on Universal Health Insurance.

5) breach of Art. 6 of the Civil Code by the plaintiff's failure to prove the circumstances in which he was allegedly discriminated against prior to entering into the contracts and in the period of their duration,

II. The judgment breaches procedural law by:

1. breaching Art. 233 §1 of the Code of Civil Procedure by violating the limits of free evaluation of evidence, consisting in the assumption that the contracts were renegotiated in the period of their duration,

2. breaching Art. 233 §1 of the Code of Civil Procedure by violating the limits of free evaluation of evidence, consisting in the assumption that the defendant's refusal to finance the non-contracted healthcare benefits provided by the plaintiff was a result of only financial difficulties.

III. The defendant also raised the allegation that the factual findings of the Court are inconsistent with the evidence gathered in this case, which follows from the court's assumption that the Health Fund imposed the rate amounts in the contracts entered into with the plaintiff.

Based on the foregoing allegations, the defendant requested that the appealed judgment be amended in its entirety and that the action be dismissed, as well as that the plaintiff be ordered to reimburse the defendant's legal costs or, possibly, that the appealed judgment be reversed in its entirety and the case remanded for re-examination to the Court of First Instance.

The Appellate Court considered the following:

Since the Act of 23 January 2003 on Universal Health Insurance at the National Healthcare Fund (*Dziennik Ustaw* no. 45, item 391 as amended) came into force, pursuant to its Art. 196 point 1, Art. 198 and Art. 202 and to the provisions of the Regulation of the Prime Minister of 28 March 2003 on the Charter of the National Healthcare Fund, the National Healthcare Fund has become a party to this action.

In the opinion of the Appellate Court, the defendant's appeal is justified. In consideration of the complainant's allegations, it is first important to note that the institution of health insurance in its

form determined by the Act of 6 February 1997 on Universal Health Insurance is very complex. It entails three types of interrelated legal relationships, i.e. the relationship between the insured person and the Health Fund (currently the National Healthcare Fund), the relationship between the Health Fund and the benefit provider, that is the Healthcare Institutions, and the relationship between the benefit provider and the insured person, that is, the patient. The interrelatedness and coexistence of these relationships is necessary for the exercise of the right to healthcare benefits. The relationship between the Health Fund and the Healthcare Institution is a contractual one, and for this reason its performance must be evaluated from the point of view of the Civil law.

In the opinion of the Appellate Court, the defendant rightly raised that it was not correct for the Circuit Court to quote the provisions regulating intervening in another's affairs without a mandate as the basis of the defendant's liability for the over-the-limit benefits, as the prerequisites for applying these provisions were not fulfilled. Pursuant to Art. 4(3) of the Act on Universal Health Insurance, healthcare benefits provided to insured persons are financed from the financial means held by the Health Fund. On the other hand, pursuant to Art. 4(2) of this Act, a contract entered into with the Health Fund is the only basis for requesting a payment from the Health Fund for benefits provided by a Healthcare Institution within the public health insurance (except for the cases provided for by the law). Therefore, it would be unjustified to concur with the opinion of the Court of First Instance that there are other, extra contractual, grounds for requesting payment from the Health Fund. If the plaintiff had not been bound by a contract with the Healthcare Fund and if he had provided healthcare benefits pursuant to the rules laid down in Art. 7 of the Act on Healthcare Institutions, then he could make a request for such payment on the basis of provisions on intervening in another's affairs without a mandate. However, in a situation whereby a contract had been entered into for the provision of medical services, as in the present case, the plaintiff is entitled to a remuneration resulting from the contract. The quantitative limits specified by the contract obviously do not concern the cases of providing healthcare benefits under the conditions specified in Art. 7 of the Act on Healthcare Institutions, as in this case arises a statutory duty to provide healthcare benefits immediately and it may not be subject to contractual limitations. Therefore, the Circuit Court's inference that accepting the defendant's position would create a possibility for Healthcare Institutions to refuse emergency assistance in life-threatening situations due to exceeded limits is incorrect, as this issue is regulated under separate provisions. In the course of proceedings the plaintiff, with whom lays the burden of proof in this matter, has not proved that the over-the-limit healthcare benefits for which invoices were issued and attached to his statement of claims, were provided with fulfillment of prerequisites specified under Art. 7 of the Act on Healthcare Institutions.

In the opinion of the Appellate Court it is also inadmissible to directly assume that the plaintiff, in providing healthcare benefits which exceed contractual limits, was intervening in "another's" affairs since, as already indicated hereinabove, the existence of three different types of legal relationships makes it impossible to speak of a simple interrelationship. Moreover, in analyzing the provisions which regulate the institution of intervening in another's affairs without a mandate, it should also be taken into account that in this particular case the prerequisites allowing the application of these provisions were not fulfilled. In particular, the prerequisite of acting to the benefit of the person whose affair is intervened in and according to the probable intention of that person and of notifying this person on the intervention. Providing healthcare benefits over the contractual limits and charging the Healthcare Fund with their costs, in a situation whereby the Fund, pursuant to Art. 4 of the Act on Universal Healthcare Insurance had an obligation to balance its expenditures and income, was hardly acting to the benefit of the Fund. In the case at issue, the plaintiff also failed to notify the Health Fund of the existing situation, despite being obliged to do so. It is true that the plaintiff presented monthly and quarterly settlements on the performance of contracts and that they revealed benefits provided over the contractual limits, but they may not be considered sufficient notification of the Health Fund. In the opinion of the Appellate Court, the inference made by the Court of First Instance that the Health Fund accepted the over-the-limits benefits because it paid for them in the first quarter of 1999 is incorrect. The records of the case do

not contain any proof of the Health Fund's payment for over-the-limit benefits to the plaintiff provided in 1999. Witness M. testified that he did not remember such payment, while witness F. was uncertain whether the plaintiff received this specific amount. Had the Health Fund accepted the over-the-limit benefits, it would have probably paid for them on an up-to-date basis. It was also an overstatement on the part of the Court of First Instance to assume that the only reason for lack of further payments was insufficient funds held by the Health Fund, as even the attached reports show that the Healthcare Fund did not pay for the over-the-limit benefits because it didn't accept them. In events of exceeding the contractual limits, the Healthcare Fund made payments only up to the amounts specified in the contracts. Pursuant to Art. 53(4) of the Act on Universal Health Insurance (in its wording as of 1 January 1999), contracts entered into by the Health Fund and the healthcare providers should determine the type, scope, conditions and rules of providing benefits, as well as the rules for settlements with the healthcare providers and the maximum amount of liability of the Health Fund towards the healthcare provider. These contracts, entered into by the plaintiff and the Mazowiecki Regional Health Fund contained these maximum amounts which limited the number of benefits to be provided, while attachments to the contracts specified the type, scope and prices of benefits to be provided. As a side-note, it's noteworthy to indicate at this point that the plaintiff, in disregard of his duty pursuant to Art. 6 of the Civil Code, failed to attach to the records of the case the contract on provision of dental benefits, despite the fact that according to the testimony of witness M., the parties were bound by a separate contract in this scope. A list of actually provided benefits related to emergency medical assistance was not attached either. It is a fact that at the beginning of functioning of the new healthcare system, it was difficult for the parties to estimate how many actual benefits would be provided and if the quantitative limits specified under individual contracts would be sufficient, but this is precisely the reason for which the contracts provided a possibility of renegotiation of financial terms and conditions, which was to take place immediately after the first quarter of 1999. Moreover, as to the contracts on provision of outpatient specialised healthcare benefits and on provision of inpatient benefits, the parties to the contract foresaw the possibility of increasing the amounts of installments if the number of actually provided benefits exceeded the number of contracted benefits by over 2% in a given period for clearing of accounts. A condition for such an increase was that the healthcare provider presented a written, content-based substantiation for the provision of an increased number of healthcare benefits and that this substantiation was accepted by the Health Fund. Individual contracts also contained a provision which required that each amendment of the conditions was to be made in writing under pain of nullity. The plaintiff has not proved to have fulfilled these duties imposed on him by the contracts, as he has failed to present to the Health Fund a written substantiation for exceeding the set limits. In the opinion of the Appellate Court, it has not been proved that the renegotiation of contracts entered into had taken place, although the Circuit Court assumed that these contracts were renegotiated in the second half of 1999. The witness F. has indeed stated that the Health Fund renegotiated its contracts with all Health Centres, but witness M. testified that in 1999 probably no annexes to these contracts were drawn up. The records of the file do not contain the annexes to the contracts entered into and, since any amendments to the contracts required a written form under pain of nullity, it is inadmissible to assume that the financial conditions had been changed. Therefore, the parties were bound by the limits of financing of the benefits by the Health Fund under individual contracts. Moreover, the funds designated for performance of tasks under individual contracts could not be used towards other purposes. Therefore, if a Health Institution did not exhaust all the funds within a certain contract, they could not be employed towards the performance of another contract, even if the second contract was underfunded. This is how this issue was regulated by the contracts.

In the opinion of the Appellate Court, the plaintiff also failed to prove that the principle of equality of parties to a legal relationship had been violated. In his testimony the witness M. did in fact mention that the Healthcare Fund "imposed" its rates on the plaintiff, but this was not proved within the meaning of the provisions of Art. 6 of the Civil Code. Moreover, the present case is concerned

with the Healthcare Institution exceeding the fixed quantitative limits and the issue of price rates for each consultation had not been raised. Art. 7 of the Act of 30 August 1991 on Healthcare Institutions charges the Healthcare Institutions with the duty to provide a healthcare benefit to a person in need of immediate assistance due to a health or life threatening situation. However, this provision does not regulate the issue of financial consequences arising from the provision of such a benefit. Art. 38 (5) of this Act stipulates that a public Healthcare Institution may not charge fees for the provision of healthcare benefits to a person entitled to them. It follows from the foregoing that it should be assumed that where a public Healthcare Institution provides a healthcare benefit to a person in a situation which threatens his/her life or health, the duty to incur the costs for a patient entitled to this benefit under public health insurance lays with the Health Fund of which the patient is a member. The plaintiff failed to prove that the invoices issued by him for individual types of provided over-the-limit healthcare benefits concerned such situations. Incidentally, the specific manner in which the plaintiff calculated the amounts due for different types of benefits covered by the issued invoices is uncertain as, adding the unpaid amounts for over-the-limit benefits revealed in quarterly settlements, contained in the records of the file, results in a different total amount than what is shown in the invoices attached to the plaintiff's statement of claims. The Appellate Court also found justified the complainant's allegation that the Court of First Instance failed to address the provisions of Art. 19 of the Act of 30 August 1991 on Healthcare Institutions, pursuant to which a patient has the right to healthcare benefits corresponding to the requirements of medical knowledge but, in a situation of limited resources for the provision of appropriate benefits, he has a right to be included in a queuing procedure establishing the order for access to these benefits in a reliable manner based on medical criteria. Therefore, where this is allowed by medical considerations, the legislator has directly provided for the admissibility of the so-called "medical queue" due to limited financial resources. Hence, the financial liability of the Health Fund for healthcare benefits provided to entitled patients may not be unlimited, which would render irrelevant the contracts and their quantitative and amount limits. A juxtaposition of Art. 19(1) point 1 of the Act on Health Institutions with Art. 4(4) of the Act on Universal Health Insurance shows that the rights of insured persons may not be deemed absolute and unlimited.

Having regard for the foregoing, the Appellate Court, pursuant to Art. 386 §1 of the Code of Civil Procedure, ruled in favour of the defendant's appeal by amending the appealed judgment, dismissing the action and adjudicating on costs pursuant to Art. 98 of the Code of Civil Procedure.