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Recommendations of the Working Group of the Congress on Mental Health and the Agreement for the Implementation of the National Mental Health Programme on systemic changes in adult psychiatric care. Part 1. Checklist for statutory solutions

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Summary

This document presents recommendations for legislative changes related to the community reform of the mental health care system in Poland. It is presented in the form of a checklist to facilitate the assessment of progress or lack of progress in implementing the proposed changes. It reflects the position of two major, active pro-reform social movements: the Mental Health Congress and the Agreement for the National Mental Health Programme.

Key words: psychiatric care reform, statutory regulations, mental health centres

"Mental health is a fundamental personal good of a human being, and protecting the rights of people with mental disorders is a state responsibility."

(Preamble to the Mental Health Act)

Introduction

The primary objective of the National Programme for the Protection of Mental Health (NPOZP, *Narodowy Program Ochrony Zdrowia Psychicznego*) for 2023–2030 is to ensure that individuals with mental disorders, including those with addictions and those experiencing a mental health crisis, receive comprehensive care and support tailored to their needs.

This objective will be achieved in adult psychiatric care, among other ways, by disseminating an integrated and comprehensive community-based mental health care model and by providing access to specialised therapeutic programmes and diagnostic procedures.

A pilot programme in mental health centres (CZPs, *Centra Zdrowia Psychicznego*) is concluding this year. Launched in 2018, the pilot aimed to test the community mental health care model in terms of organisation, financing, quality, and accessibility to healthcare services. The pilot's findings should inform the implementation of systemic solutions. A prerequisite for these solutions is the timely enactment of the relevant statutory regulations.

The Working Group of the Mental Health Congress and the Agreement for the Implementation of the NPOZP was tasked with developing recommendations on the key elements of the community model to be introduced following the pilot. These recommendations address organisational and funding issues requiring statutory regulation. They are presented in a checklist format to facilitate the Ministry of Health's evaluation of related projects. This study focuses on selected critical issues, informed by the pilot's experience, that the Working Group deems essential for achieving the NPOZP's goals. It does not comprehensively address all aspects of statutory regulation or delve into legislative drafting specifics.

The Working Group plans to conduct a similar study on organisational standards in CZPs, which will be established by the Minister of Health through a regulation (Warsaw, 27 January 2025).

No.	**Checkpoints** (meeting the requirements: yes/no) Annotations
1	**General issues**
1.1	**Funding allocation for psychiatric care and addiction treatment** The National Health Fund (NFZ, *Narodowy Fundusz Zdrowia*) shall allocate annual financial resources for psychiatric care and addiction treatment services. **This allocation must be no less than 7% of the total healthcare service costs** referred to in Article 117, Section 1, Paragraph 1 of the Act on Healthcare Services Financed from Public Funds, as specified in the NFZ's financial plan for each year. However, for the years 2026-2031, the minimum allocation may be adjusted as follows: 5.50% of total healthcare benefit costs in 2026 6.00% of total healthcare benefit costs in 2027 6.25% of total healthcare benefit costs in 2028 6.50% of total healthcare benefit costs in 2029 6.75% of total healthcare benefit costs in 2030 7.00% of total healthcare benefit costs in 2031. **Commentary:** *While the Act on Healthcare Services Financed from Public Funds mandates a minimum level of overall healthcare expenditure relative to GDP (Article 131c), it does not guarantee a minimum funding level specifically for psychiatric care and addiction treatment. This lack of guarantee persists despite decades of discriminatory treatment in this area and the significant risk of social exclusion for individuals experiencing mental health crises.* *For many years, Poland's funding for psychiatric care and addiction treatment has remained below the EU average (6-7%), with the National Health Fund reporting a figure of 4.5% in 2024. Staff costs in mental health and addiction treatment facilities account for over 90% of total expenditures.* *To significantly improve access and quality of care, it is essential to increase staffing levels, including psychologists, psychotherapists, community mental health therapists, and care coordinators. Furthermore, ensuring suitable conditions for providing assistance is crucial.* *Implementing statutory guarantees to secure at least a minimum European-level funding will substantially enhance the financial sustainability of psychiatric care. A funding level of 6% should be achieved within two years, and 7% within four years.*
1.2	**National Centre for Mental Health** The monitoring and coordination of mental health protection activities are conducted by the **National Centre for Mental Health**, a state budgetary unit that reports to the Minister of Health. The Centre's specific duties and operational procedures are established by law. **Commentary:** *As stated in the provisions of the Public Health Act (Chapter 2a), the National Centre for Counteracting Addictions, another state budgetary unit under the Minister of Health, already operates to prevent and address addiction-related issues.* *The distinct and significant importance of mental health protection necessitates the creation of a specialised national institution dedicated to this area of healthcare. The National Centre for Mental Health could function based on principles similar to those of the National Centre for Counteracting Addictions.*

	A compelling rationale for establishing this Centre lies not only in the need to coordinate activities during the transition of psychiatric care towards a community-based approach, but also in providing the Ministry of Health with a structured expert foundation for formulating and executing mental health policy. Equally important is the requirement to coordinate activities with other governmental sectors and specific state policies.
1.3	**Specialised psychiatric care** Specialised psychiatric care, implemented through **specialised health programmes and separate funding for university psychiatric clinics** that meet the conditions specified in the Act, is introduced. The detailed conditions and the list of clinics funded separately are specified in a decree issued by the Minister of Health. Specialist health programmes in the field of psychiatric care and addiction treatment constitute a special form of health programmes as specified in the Act, referred to in Article 48 of the Act on Healthcare Services Financed from Public Funds. Specialised health programmes are implemented by the NFZ on the order of the Minister of Health. The draft of a specialised health programme is developed by the National Centre for Mental Health in cooperation with relevant scientific societies. **Commentary:** *Specialised psychiatric care (specialised health programmes) is a necessary adjunct to the therapeutic offer of the CZP network for selected mental disorders that require specific forms of therapy (e.g. eating disorders, severe personality disorders, or other particularly persistent mental disorders) and are provided by facilities with the appropriate staff and experience, including specialist psychiatric hospitals.* *To supplement the system at a highly specialised level, university psychiatric clinics, due to the nature of their tasks, require different funding rules.*
1.4	**Primary care provider (PCP) tasks** The **tasks of the primary care provider** (PCP) within the community mental health model are defined. **Commentary:** *The need to define the tasks of the PCP stems from the National Programme for the Protection of Mental Health (NPOZP).* *It is defined in the NPOZP under the main objective: "To provide people with mental disorders, including those with addictions and those experiencing a mental health crisis, with comprehensive and complex care and support appropriate to their needs"; specific objective 1a: "to disseminate an integrated and comprehensive community-based mental health care model"; point 6 (task for the Minister of Health).* *This matter requires regulation at the statutory level, as well as an appropriate implementing act.*
1.5	**CZP cooperation with social assistance and support units** The principles and methods by which **CZPs cooperate** with **social assistance units**, entities implementing **social-occupational activation**, and s**upport for families** are defined. **Commentary:** *The need to identify these issues stems from the National Programme for the Protection of Mental Health (NPOZP).* *It is specified in the NPOZP under main objective No. 1: "To provide people with mental disorders, including those with addictions and those experiencing a mental health crisis, with comprehensive care and support appropriate to their needs"; specific objective 1f: "coordinate*

	available forms of care and assistance," point 2 (task for the Minister of Health in consultation with the Minister responsible for social security and the Minister responsible for family affairs). *This matter requires regulation at the statutory level, as well as appropriate implementing acts.*
1.6	**County Mental Health Councils** County councils may establish **County Mental Health Councils**, which serve as consultative, advisory, and initiative bodies, operating on principles similar to those of district councils for senior citizens. The membership of the County Mental Health Council includes, but is not limited to: representatives of individuals with lived experience of mental health challenges and their support networks; entities and organisations within the county that provide support to individuals with mental health needs (CZPs, social welfare agencies, vocational activation institutions, etc.); groups and organisations engaged in mental health promotion and prevention, including educational institutions. **Commentary:** *The County Government Act enables the establishment of county councils for senior citizens, which have a consultative, advisory, and initiative role (Article 3f).* *There is a compelling argument for establishing similar councils dedicated to mental health at the community level. These councils would contribute to the engagement of local communities in various mental health initiatives.* *Their objectives would include representing the needs of individuals with mental health challenges by providing feedback and consultation on local authority decisions, and initiating and undertaking local actions related to mental health promotion, prevention, and social inclusion.*
1.7	**Implementation timeline** The **implementation of the new nationwide system of solutions** shall occur **within two years of the Act's entry into force**. The Act shall specify the operational rules for adult psychiatric care in CZP areas from the Act's entry into force until the respective CZP begins implementing its contract. **Commentary:** *Based on the pilot implementation, a two-year timeframe is considered sufficient to establish the CZP network nationwide. However, it is essential to implement transitional solutions to ensure continuous operation, as the new model cannot be launched simultaneously in all CZP areas.*
2	**Organisation of CZPs**
2.1	**CZP as a medical facility** A CZP is a **medical facility** operated by a medical entity. CZPs provide comprehensive and integrated psychiatric care to **individuals aged 18 and over with mental disorders who reside within the CZP's operational area** (refer to sections 4.1-4.4). This care is delivered in the form of five core types of services: **emergency, outpatient, day care, community care, and hospital care**. **Commentary:** *According to the Medical Activities Act, a medical facility is "a group of assets through which a medical entity performs a specific type of medical activity" (Article 2, Section 1, Paragraph 14). Current regulations prohibit the integration of inpatient and 24-hour health services*

	(e.g. hospitals) with outpatient services (including day and community services) within a single medical facility. This absurd restriction should be lifted for CZPs. *Conversely, the Mental Health Act stipulates that "the medical entity operating the Mental Health Centre shall provide comprehensive health care for individuals with mental disorders within a defined territorial area, encompassing emergency, outpatient, day care, hospital, and community care" (Article 5a). Therefore, CZPs should provide all five core services, subject to point 2.3, within a single medical facility rather than in separate facilities, as was observed during the pilot.*
2.2	**CZP service locations** Outpatient, day care, and community care **services are located within the CZP's operational area**. Emergency and hospital services may be located within a nearby area, specifically no further than a neighbouring county.
2.3	**Subcontracting emergency and hospital care** If a medical entity operating a **CZP does not have an in-house psychiatric (hospital) ward**, emergency and hospital care shall be **provided by a subcontractor** selected from the medical entities listed in the provincial plan of CZP operational areas (refer to point 4.2). The Act specifies the rules for subcontracting emergency and hospital care, including the required elements of these contracts, for all medical entities operating CZPs, including private providers. A tender procedure shall not be required. **Commentary:** *The Act on Healthcare Services Financed from Public Funds allows for subcontracting healthcare services under agreements with the NFZ, if the agreement so provides (Article 133). The NFZ agreement includes a list of subcontractors (Article 136, Section 1, Paragraph 3).* *The pilot programme highlighted challenges in subcontracting hospital services for CZPs without in-house psychiatric wards. Therefore, potential subcontractors for inpatient services should be identified in the provincial plan of CZP operational areas. The Act should specify the rules for concluding subcontracting agreements (without a tender procedure), including the required contract elements. These rules can be modelled on the provisions of the Medical Activities Act regarding the awarding of contracts for health services (Articles 26, 26a, and 27), without a tender procedure, applicable to all medical entities, including private providers. It is anticipated that subcontracting inpatient services will become significantly easier after the pilot, due to the termination of separate NFZ contracts for psychiatric hospitalisations in "acute" wards outside of CZP contracts.*
2.4	**CZP operational area** **Each CZP shall operate within a single operational area** (refer to sections 4.1-4.4). A **medical entity may operate only one CZP**, except for medical entities that operated two CZPs as of 31 December 2024. In these cases, operating two CZPs will be permissible. **Commentary:** *During the second phase of the pilot (after 2021), some medical entities were permitted to operate additional CZPs, which in some instances conflicted with the programme's objectives. However, arbitrarily altering the existing status quo for these entities would create more challenges than benefits.*

2.5	**CZP financial autonomy** CZPs shall be **self-balancing, separate organisational units** (medical facilities) of medical entities with **financial autonomy**. Each CZP shall maintain its own accounting records and prepare **independent financial statements**. **Commentary:** *According to the current Medical Activities Act, a medical entity may stipulate in its organisational regulations that a specific medical facility prepares a separate balance sheet (Article 2, Section 3). For CZPs, this should be mandatory due to their population-based lump-sum funding. The aim is to ensure maximum transparency of CZP financial management and to guarantee that lump-sum funds are used exclusively for CZP activities (refer to point 6.10).* *CZPs will prepare standalone financial statements. Medical entities operating CZPs will prepare consolidated financial statements that include the CZP's financial statements. As per the Accounting* *Act, „an entity that includes organisational units preparing independent financial statements prepares consolidated financial statements that are the sum of the financial statements of the entity and all its branches (establishments)" (Article 51, Section 1).* *Accounting for a CZP may be outsourced to an accounting office.*
2.6	**CZP staff qualifications** CZPs shall employ staff with **qualifications appropriate** to their positions. The Minister of Health shall issue regulations **specifying the required qualifications for various positions** within the CZP's core activities, taking into account patient safety, the need to ensure appropriate quality of healthcare services, and employment efficiency. These regulations shall apply to all medical entities, including private providers. **Commentary:** *The Medical Activities Act currently delegates the issuance of qualification regulations only for medical entities that are not private providers (Article 50, Section 5), and does not address the specific needs of CZPs.* *To ensure proper functioning of CZPs, a separate regulation specifying the required qualifications for personnel involved in CZP core activities is needed, regardless of the medical entity's organisational form (e.g. capital company, independent public healthcare institution, etc.).*
2.7	**CZP head selection** In medical entities that are not private providers, **the head of the CZP shall be selected through a competition** conducted in accordance with the Medical Activities Act. The selected candidate shall either be employed under an employment contract or enter into a six-year civil law contract. **Commentary:** *This provision supplements the list of positions in non-business entities that require competition under the Medical Activities Act (Article 49, Section 1).*
2.8	**Notification and Coordination Points (PZKs)** **The tasks and functioning of Notification and Coordination Points (PZKs**) and the required qualifications of PZK staff will be defined. Each PZK should serve no more than 80,000 individuals aged 18 and over residing within the CZP's operational area.

2.9	**Active care** The definition and principles of active care shall be established. Individuals with mental disorders receiving **active care from CZPs shall be assigned to a designated care coordinator.** The Act shall specify the principles of coordination, the required qualifications and tasks of coordinators, and the maximum number of individuals with mental disorders supported by each coordinator. Care coordinators will not be permitted to provide other healthcare services during the hours in which they perform their coordinator duties. **Commentary:** *The role of care coordinators needs to be regulated at the statutory level. Relevant regulations for coordinators in other healthcare areas can be found in the Act on Specific Geriatric Care (Articles 26 and 27) and the Act on the National Cancer Network (Article 2, Paragraph 4 et seq.).*
2.10	**Recovery assistants** The **employment of recovery assistants in CZPs is mandatory**. Recovery assistants shall be employees of CZP core activities. **Commentary:** *The Minister of Health has announced the inclusion of the market qualification "Supporting people experiencing mental crises in the process of recovery by people with experience of psychosis (recovery assistant)" in the Integrated Qualifications System (M.P. 2022 item 581). This represents the initial step in introducing this new profession into psychiatric care. The pilot programme highlights the need for appropriate statutory regulation.*
2.11	**Time limits for providing assistance** The Act shall **specify maximum time limits for providing** the following: Assistance at the Notification and Coordination Point: immediately upon request. Psychiatric services in urgent cases: within 3 days of the request.
3	**Quality**
3.1	**Organisational standards** The Minister of Health shall establish, by ordinance, the **organisational standards for healthcare within CZPs**, ensuring appropriate quality of services. CZPs shall comply with these standards. **Commentary:** *In accordance with the Medical Activities Act (Article 22, Section 5), the Minister of Health may determine organisational standards for healthcare in specific medical fields or medical entities. For CZPs, these standards should be mandatory, not optional.*
3.2	**Diagnosis and treatment guidelines** The Minister of Health, after consulting with the Agency for Health Technology Assessment and Tariffication, shall publish, by way of public notice, **recommendations (guidelines) for diagnosis and treatment in community care**. These guidelines will be developed by relevant national scientific societies of mental health specialists. **Commentary:** *Pursuant to the Act on Healthcare Services Financed from Public Funds (Article 11, Sections 3 and 4), the Minister of Health may publish recommendations for diagnostic and treatment procedures within publicly funded services, developed by relevant national scientific societies.*

	Similarly, the Act on the National Oncology Network (Article 24, Sections 1-5) mandates that the Minister of Health publish key recommendations for oncology care to unify clinical practice and improve quality of care. *For CZPs, the development and publication of such recommendations should be mandatory, as in oncology care. The National Centre for Mental Health may be tasked with initiating the development of these guidelines.*
3.3	**Accreditation** **CZPs shall be subject to accreditation**, confirming their compliance with accreditation standards for the provision of healthcare services and the operation of CZPs. Accreditation shall be conducted in accordance with the principles and procedures outlined in Chapter 4 of the Act on Quality in Health Care and Patient Safety. **Commentary:** *Chapter 4 of the Act on Quality in Health Care and Patient Safety, entitled "Accreditation in Health Care," consists of the following sections: General Provisions; Assessment Procedure, Granting or Refusal of Accreditation; and the Accreditation Council. Beyond specifying that CZPs are subject to accreditation, no additional regulations are necessary.*
3.4	**Quality indicators** The Minister of Health shall establish, by ordinance, **quality indicators for psychiatric care,** taking into account its specific nature and the need to ensure high-quality services. The National Centre for Mental Health, in collaboration with relevant scientific societies, is drafting a set of these indicators. **Commentary:** *The Act on Quality in Health Care and Patient Safety (Article 2) regulates the use of quality indicators in healthcare. However, the specificity of psychiatric care necessitates tailored regulations.*
4	**Provincial CZP area plans**
4.1	**Plan development and approval** **The provincial governor shall prepare**, and the Minister of Health shall approve, **the provincial plan for CZP operational areas.** The plan shall be updated as necessary. The Act shall specify the principles, procedures, and criteria guiding the governor in the preparation and updating of the plan. In preparing the draft plan, the **governor shall consider the CZP operational areas as defined in the Minister of Health's regulation on the mental health centre pilot programme.** The governor shall submit the draft plan to the Voivodeship Marshal, the Voivodeship County Committee, the President of the NFZ, the Voivodeship Council for Social Dialogue, and the Voivodeship Consultant in Psychiatry for consultation, with **a 30-day period for submitting comments**. The Minister of Health shall seek the opinion of the Mental Health Board before approving the plan. The plan approved by the Minister of Health shall be **published by the governor, by way of public notice, in the provincial official gazette.** **Commentary:** *Assigning the provincial governor the task of drafting the plan avoids potential conflicts of interest that could arise if local authorities, who own medical entities, were responsible for this task.*

	It is worth noting that the governor already prepares similar plans, such as the provincial action plan for the National Medical Rescue System and the provincial transformation plan, both of which are approved by the Minister of Health.
4.2	**Plan contents** The provincial plan of CZP operational areas shall include: **CZP operational areas**; locations of **Notification and Coordination Points;** **medical entities that may provide emergency and inpatient hospital care** where the medical entity operating a CZP does not have an in-house psychiatric ward (potential subcontractors).
4.3	**CZP operational area definition** CZP operational areas shall cover **administrative divisions of the country or so-called delegations** (districts of Warsaw and former districts of Kraków, Łódź, Poznań, and Wrocław). In cities with over 100,000 residents, the **operational area may include specific municipal subdivisions or streets**. **Commentary:** *This aligns with the direction established in the 2015 amendment to the Mental Health Act (Article 5a), pursuant to which "the medical entity operating a Mental Health Centre (CZP) shall provide comprehensive healthcare for individuals with mental disorders within a defined territorial area, encompassing emergency, outpatient, day care, hospital, and community care."* *The Act on Municipal Self-Government (Article 5) allows for the creation of auxiliary units, such as districts, housing settlements, and similar units. This is standard practice in large cities.* *The Regulation of the Minister of Health on the scope of essential information processed by healthcare providers, the detailed registration process, and its transfer to entities responsible for financing healthcare services from public funds will require amendment. These changes should extend the scope of data transmitted by healthcare providers to include, in addition to the municipality code (TERC), the street code (ULIC) and building number within the TERYT system.*
4.4	**Population size covered by a CZP** CZP operational areas **should serve between 50,000 and 150,000 residents aged 18 and over**. The population may be up to 5,000 below the lower limit or up to 15,000 above the upper limit, subject to the consent of the Minister of Health, granted after obtaining the opinion of the Mental Health Board, based on a justified application from the governor prior to the preparation of the draft plan or its update. The procedure shall be specified in the Act. In cities with over 200,000 residents aged 18 and over, the upper population limit for a CZP operational area may be 200,000, subject to the consent of the Minister of Health granted under the same rules as above. **Commentary:** *Experience from the CZP pilot programme demonstrates that serving large populations (e.g. 200,000 residents) creates operational difficulties and necessitates functional divisions. Therefore, exceeding the threshold of 150,000 residents should be exceptional. The Act should include a strong recommendation that governors establish smaller CZP operational areas in cities/districts with 180,000-250,000 residents, covering municipal auxiliary units or specific streets.*

5	Contract awarding
5.1	**Contract awarding process** Contracts for the provision of healthcare services within CZPs shall be concluded through a bargaining procedure, with specific regulations governing these proceedings. The purpose of the procedure is to select the most advantageous offer ensuring comprehensive and integrated psychiatric care in **five core service areas (emergency, outpatient, day care, community, and hospital care) for residents aged 18 and over residing within the CZP operational area.** The Minister of Health shall, by ordinance, determine the **detailed criteria for the selection of offers in proceedings for the conclusion of contracts for the provision of healthcare services within CZPs**. **Commentary:** *Pursuant to the Act on Healthcare Services Financed from Public Funds (Article 143), contracts for the provision of healthcare services may be concluded through a bargaining procedure in cases specified in the Act. These cases are set out in Article 144. It is necessary to add an additional premise — proceedings for the conclusion of contracts for the provision of healthcare services within CZPs.* *As, under the community-based care model, a uniform annual per capita rate applies nationwide and the contract does not specify the number of services provided, the selection of the most advantageous offer is based not on price or service volume, but primarily on its substantive merit. This necessitates the introduction of specific regulations.* *Detailed selection criteria shall be specified in a separate regulation issued by the Minister of Health. The current regulation on the detailed criteria for selecting offers in proceedings for the conclusion of contracts for the provision of healthcare services is, due to the scope of the statutory delegation, not suitable for regulating this matter.*
5.2	**Contract alignment with the provincial plan** The CZP contract award procedure **shall align with the guidelines of the approved provincial plan for CZP service areas, with regard to the territorial area covered by the procedure**, including the CZP service area as well as the locations of the Notification and Coordination Points and any potential subcontractors providing emergency and hospital care.
5.3	**Invitation to conclude contracts** For the purpose of conducting negotiations, following publication of **the announcement**, the **NFZ shall invite medical entities** that, as of the date the Act enters into force, provided psychiatric care services (excluding addiction treatment) covering **at least three of the five core service areas** referred to in Article 5a of the Act on Mental Health Protection (emergency, outpatient, day care, community, and hospital care). The place where these services are provided should be located within the operational area specified in the approved provincial plan of CZP service areas, with the exception of emergency and hospital care (see point 2.2). **If no entities meet the above conditions**, invitations shall be sent to entities that provided services covering **two core forms of care** (as of the date the Act enters into force).

5.4	**Contracts in the case of equivalent bids** In the case of **bids deemed equivalent** in the course of the procedure with regard to the evaluation criteria, the **contract shall be concluded with the entity that implemented the CZP pilot programme** (if applicable).
6	**Population-based lump sum funding**
6.1	**Funding models** CZP funding shall be provided through: **population-based lump sum funding**; **fee-for-service payments**. Population-based lump sum funding is a method of financing psychiatric healthcare services provided by CZPs to persons aged 18 and over who reside within their operational area. Fee-for-service payment applies to psychiatric healthcare services provided to persons who do not reside within the operational area (including services provided under EU coordination regulations). Fee-for-service payment also applies to selected addiction treatment services, regardless of the beneficiary's place of residence. The list of psychiatric and addiction treatment services subject to fee-for-service payment (i.e. financed outside the lump sum) is specified in the Regulation of the Minister of Health on Guaranteed Services in Psychiatric Care and Addiction Treatment (the Basket Regulation).
6.2	**Population-based lump sum** **The population-based lump sum covers** the psychiatric services provided by CZPs, as specified in the Regulation of the Minister of Health on Guaranteed Services in Psychiatric Care and Addiction Treatment (the Basket Regulation).
6.3	**Lump sum – exclusions** **The population-based lump sum does not cover**: addiction treatment services; psychiatric and addiction treatment services for children and adolescents; forensic psychiatry services; care and treatment services; nursing and care services. The population-based lump sum also does not cover specialised psychiatric care provided in the form of specialist health programmes and services provided by university psychiatric clinics (as regulated by the Minister of Health) and having separate contracts with the National Health Fund (see section 1.3)**.**
6.4	**Population-based lump sum – calculation details** **The population-based lump sum** is calculated by multiplying the number of individuals aged 18 and over residing within the CZP's service area by the annual per-person rate. Regarding **residents of social welfare** homes for the chronically mentally ill and adults with intellectual disabilities located within the CZP's service area, the annual **per-person rate is increased 3.1 times**.

	The population-based lump sum **is not differentiated** based on whether the CZP has a hospital ward. CZPs without a hospital ward must have a subcontract for hospital care. The number of eligible residents is determined as follows: The President of the Central Statistical Office provides the number of residents aged 18 and over as of 31 December two years prior. If the Central Statistical Office cannot provide this data (e.g. because the CZP's service area is smaller than the national statistical divisions), the number is determined by the local mayor, city president or county head responsible for the CZP's operational area, based on a proposal from the relevant NFZ Regional Office director. The number of residents of social welfare homes is determined as of 31 December of the year preceding the year for which the population-based lump sum is calculated. This number is determined by the NFZ Regional Office director based on data obtained from the directors of social welfare homes.
6.5	**Adjustments to the annual per-person rate** **The annual per-person rate is adjusted proportionally to increases in healthcare service costs,** as specified in the NFZ financial plan (Article 118, Section 2, Paragraph 1, Letter e of the Act on Healthcare Services Financed from Public Funds). Both the annual per-person rate and the population-based lump sum are updated semi-annually. The Act outlines the annual adjustment mechanism following the finalisation of the NFZ financial plan for the given year.
6.6	**Future differentiation of annual per-person rates** Starting in the year following the fifth anniversary of the Act's entry into force, **differentiated annual per-person rates shall be introduced across the operational areas of CZPs**, based on: Age – and gender-segregated groups of insured individuals; separate groups of healthcare services, including services provided to individuals with severe mental disorders; the health risk associated with a given insured group for a specific group of healthcare services (especially severe mental disorders), compared to a reference group. Following this differentiation, the annual per-person rate in a given year must not be lower than the rate in the last period of the previous year, adjusted for cost increases in accordance with the principles described above (see section 6.5). The Minister of Health shall establish, by regulation, detailed procedures and criteria for determining the annual per-person rate, including the relevant algorithm. **Commentary**: *This proposed funding solution is modelled on the fund allocation mechanism for voivodeships outlined in the Act on Healthcare Services Financed from Public Funds. Specifically, Article 118(3) of this Act stipulates that the number of insured individuals in each voivodeship department is stratified by age and sex, and subsequently segmented into two healthcare service categories: specialist services and other benefits. The allocation algorithm thus takes into account the number of insured individuals while also adjusting for the health risks of specific insured groups within each service category, compared to a reference group. In the proposed model, psychiatric services provided to individuals with severe mental disorders are substituted for the specialised service component of the voivodeship fund allocation mechanism. Severe mental disorders (also referred to as severe mental illness or serious mental illness), according*

	to the World Health Organisation (WHO), include, in particular, schizophrenia, bipolar affective disorder, and major depressive disorder. These disorders are characterised by their chronic nature and frequent association with substantial disability. On average, individuals with severe mental disorders experience a reduction in life expectancy of 10 to 20 years compared to the general population. Publications from the European Commission underscore that the provision of long-term psychiatric care for individuals with severe mental disorders represents a major challenge for the reform of mental health systems in various nations.
6.7	**Patient migration and lump sum adjustments** The Community Mental Health Centre (CZP) finances the costs of its psychiatric services (see section 6.2) provided to individuals over 18 years of age residing in its service area, even when those services are delivered by CZPs operating in other service areas (referred to as patient migration). In such cases, **the National Health Fund (NFZ) reduces the monthly population-based lump sum accordingly**. The Director of the NFZ Regional Office provides the CZP operator with detailed information on the reduction amount, including the number and value of individual billed services provided by other providers, before the reduction is applied. The reduction applies only to services covered by the population-based lump sum. **Commentary** *This practice continues the solutions implemented during the CZP pilot period. The lump sum reduction applies exclusively to services provided by CZPs in other service areas. It is anticipated that system changes following the pilot's conclusion will result in a single operational agreement with each CZP operator. Other psychiatric care units will continue to provide services under existing subcontracting arrangements.* *It is important to note that the NFZ will contract for psychiatric care solely with CZPs. This stipulation does not extend to specialised health programmes, university psychiatric clinics, forensic psychiatry, residential care and treatment facilities, or nursing care services.*
6.8	**Services outside the lump sum** The CZP receives monthly payments for healthcare services provided outside the population-based lump sum, including services delivered to patients residing outside the centre's service area and selected addiction treatment services as defined in the Basket Regulation. The annual value of these services provided to newly enrolled patients, or to patients re-enrolling after a one-year break **following 31 December 2024, must not exceed 10% of the annual population-based lump sum value** (excluding deductibles). This limitation does not apply to selected addiction treatment services (see section 6.1). **Comment:** *This restriction does not apply to patients who continue treatment at the CZP or its subcontractors, or whose treatment interruption was shorter than 12 months.*
6.9	**Unit pricing for services** When accounting for the services mentioned in sections 6.7 and 6.8, unit **prices for individual services shall be established annually by the President of the NFZ, in agreement with representative organisations of CZP operators**, by 31 December of the preceding year. Representative organisations are defined as those representing at least 30% of CZP operators. The relevant legislation specifies the procedure, deadlines for each stage, and rules for the negotiation process.

	If an agreement is not reached by the specified deadline, the Minister of Health will determine the unit prices for specific services through an ordinance, prioritising the interests of patients and ensuring proper implementation of CZP agreements.
6.10	**Financial management of CZP funds** At least 95% of the funds transferred by the NFZ under the agreement with the CZP operator (population-based lump sum after deductions + payments for services rendered) during an annual period must be used exclusively for: CZP operating costs, including depreciation of fixed assets and tangible and intangible assets; taxes, fees, and other mandatory charges. Unused funds exceeding 5% of the total amount received annually must be returned to the NFZ within six months after the end of the year. **Commentary:** *The population-based lump sum funding model requires that public funds received under the NFZ agreement be used to finance CZP operating costs. Allowing a 5% margin for the operator is based on the need to maintain economic efficiency.*

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Non-peer-reviewed work.

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