

MAŁGORZATA RUTKOWSKA-PODOŁOWSKA, ŁUKASZ POPŁAWSKI,
MAŁGORZATA ZALESKA-TSITINI*

Health care policy in Poland and in selected European Union countries: Attempts at reducing fast increasing medical care costs

A thing that would be good in every respect does not exist
Horace

Key words: public health care services, deficit, saving cuts, services provided

S u m m a r y: The objective of the paper is the discussion of the health care systems in selected countries. The paper presents the four basic models of health service, i.e. the Bismarck's model, the Beveridge's model, the residual model and the Siemaszko's model. In the following part, the paper presents information on the deficit in the health care service in Poland, as well as the deficit in selected European countries, that is in Germany, in the United Kingdom, in France, Italy or the Netherlands. It has been emphasised that a battle is currently waged throughout Europe about reducing expenses for health care services without any radical limitation in the scope of the public health care benefits. The shortage of financial funds and ever increasing expenditures for medical care put in a difficult situation not only physicians, but also patients. The subject matter of the analysis is indication of the possibilities of reducing excessive costs of the public health care services, but without severe reducing of the scope of public health care benefits. It has been emphasised that real changes may occur from development of privatisation in the competitors. The summary presents expenditures for health care in the years 1999–2008 in selected European countries as % of GDP.

* Eng. Małgorzata Rutkowska-Podołowska, PhD—Institute of Organization and Management, Department of Economics and Commercial Law, Wrocław University of Technology; Eng. Łukasz Popławski, PhD— Department of Economics and Economic Policy, University of Agriculture in Krakow; Małgorzata Zaleska-Tsitini, MA—University of Lower Silesia in Wrocław.

1. Introduction

The social care systems in the European Union countries are related to the history, tradition and culture of the given country. There are four basic models in the health care systems at present (8):

- the Bismarck's model;
- the Beveridge's model;
- the residual model, called the X model;
- the Siemaszko's model.

The Bismarck's model was introduced by prince Otto Eduard Leopold von Bismarck in 1883. This model has become the template for creating insurance for almost all European countries in the early 20th century. Health care services are financed from premiums (paid by the employee and the employer), which are most often obligatory. The process of making decisions is decentralised, and the State creates precise legal frames of functioning of the entire system. The important thing is that re-funding medical care costs may be provided in full or may include some share of the insured in financing.

After World War II, the master system of the English national health care services was introduced in the United Kingdom in 1948, based on the project by Lord William Beveridge. This model is called the Beveridge's model. It excludes medical care from the social insurance system and calls for a special fund for it, financed from general taxes. The leading idea of this model is guaranteeing social security to all citizens, the so-called principle of equality of citizens. The state controls execution of health care services by health care facilities. Access to health care services is free. Hospitals are financed mostly by the central budget or are assigned limits of financial funds. The above model includes also voluntary supplementary insurance facilities which are dedicated to increasing the standard of medical care and expanding its scope.

The residual model, called the X model, rejects or seriously limits public responsibility for allowing citizen access to health care. Health care services are financed with voluntary individual premiums, thus the private sector has the dominant role. The area of public health is thus separated from individual health care, and the health care sector is regarded as an open field for economic activity. Financing of services is based on private insurance or on individual direct financing. The residual model includes the public sector which covers only persons in special need, including very poor or old people.

In the Central and Eastern Europe, the Siemaszko's model (or the budget model) has been functioning since early 20th century.¹ The principles of its functioning were developed by Mikołaj Siemaszko (the health care commissar in the Soviet Union in 1930s). The basic premises of this model are: financing health care services from

¹ After the collapse of the communist system this model is practically not present in any European country.

taxes through the budget, free complete range of services, except for some medicines, equal access to services for everyone and the monopoly of the state health care service. This model proved to be fiction, pure theory. It is now regarded as a historical form, and the states in which this model was functioning are restoring their insurance systems.

2. Methodology

The paper uses the descriptive, statistical and analytical methods. The descriptive method has been used as a primary tool. It consisted in isolating and describing a specific phenomenon of the effect of water quality on health. The comparative analysis was used in the following part of the paper, which indicated all changes and abnormalities and deviations from the accepted standards.

The results have been provided in the tabular form.

3. Results and discussion

The social and economic transformation in Poland at the end of the 20th century forced the health care system reform. The condition of the health care system, the dispreference of expenses for health care, as well as the reality of the free-market economy determined the replacement of the previous supply system for health care services financed from the state budget with the insurance system based on premiums paid into health care funds, which is at present the National Health Fund.

On 6 February 1997, the act on common health care insurance was passed and approved, which became effective on 1 January 1999 (the act on common health care insurance of 1997, Dz. U. no. 28, Items 153 and 75, Item 468, as amended). The change in the system of financing health care service means in practice that the costs of its maintenance will be borne in the most part by the insured. The premium, initially in the amount of 7.5% and its increase in the following years up to the level of 9%, which is paid by all citizens for health care insurance, has not basically improved the underfinanced and indebted industry, as it was not sufficient for the financing of the system. Under these circumstances, some amount should be guaranteed with the budget act for the disposal of the health department for the activities related to health care, but increasing the premium would be a better way.

The creator of the common health insurance assumed that it would bring benefits to both the insured and the provider of medical services. The insured expected from the new system improvement in the health care system condition and respecting the rights of the patient. The health care services expected from the reform quick rise in salaries. However, until now nothing has changed. The reason was that it was forgotten that the act created only some organisational and financial premises for introduc-

tion of competition in the medical services market. Only creating such competitiveness should, among others, contribute to enhancing quality of medical services, as well as improving the attitude of health care employees to patients. Thus, any visible improvement in the condition of health care services is still to be seen.

Problems with health care services appear not only in Poland. Even the countries where the health insurance system is well developed have been touched with crisis. A battle is waged throughout Europe about reducing expenses for health care services without any radical limitation in the scope of the public health care benefits. The governments of many countries consider the plans for:

1. Imposition of limits on expenditures;
2. Withdrawal from very expensive therapeutic methods, as well as
3. Closing down some medical facilities.

Implementing the savings concepts, however, faces major resistance on part of medical circles. Physicians believe that “a clerk is not capable of assessing whether some treatment is justified for a specific patient, as these are matters purely medical. However, despite objection of some professional groups (pharmacists, physicians), many persons demand “general overhaul” and “efficient medicine” for the public health care service.

The preliminary reform steps have already been undertaken, among others, in Germany, in the United Kingdom, France, Italy or the Netherlands.

A characteristic feature of the German health care system is interference of the state in the health care policy, thus health insurance funds apply the policy of expenses focused on income of the insured. The insured, benefitting from the state, obligatory health care insurance, pays EUR 10 for the first visit with a physician per quarter. If the beneficiary enjoys private insurance, he/ she will pay for the visit from his/ her own funds, and then the insurer will refund the incurred costs. The insured under the state insurance will always pay for hospital treatment for the first 14 days of hospital stay. The fee is settled on a day-to-day basis. Since 1993, hospitals, chemist’s facilities, beneficiaries of refunding of patients’ medical care costs (through 571 non-commercial health insurance funds) had to observe the authorities-agreed upper limits of remuneration and fees for the services. As the system was proficient in the years 1992–1994, the deficit of the funds was eliminated in the amount of USD 5.7 bn, and they won the surplus of USD 6 bn. At present, however, debts have reappeared and amount to USD 3 bn (3; 7). A broadly understood health care takes 11% of the gross domestic product of Germany, i.e. EUR 230 m. The statutory health insurance funds which insure 90% of residents of Germany spent almost EUR 144 bn in 2002 for medical services. Their deficit was EUR 3.3 bn, and in 2003, despite permanently increasing premiums for health care, got even bigger. In 1990, the premium was 12.6% of gross salary, and increased in 2003 to 14.4% (11). The crisis in the German health care system is caused, most of all, by:

- the society getting older (life expectancy in men is 74.8 years, in women: 80.8 years);

- bad economic situation of the country (increase in unemployment);
- technical and technological progress (new methods of treating and new medicines are developed).

The United Kingdom's NHS (National Health Service) is under the crisis. Lack of finances may lead to hospitals suspending reception of patients, except for sudden cases. The demand for ambulance services is on the increase, and administrative expenses are abruptly increasing, which in turn leads to limitation of the services provided by hospitals, delaying planned operations and purchases of equipment. The United Kingdom is starting to stand apart from other Western countries in the area of modern medical equipment, e.g. magnetic resonance scanners (USD 1.7 bn per unit) are still something rare in most of NHS hospitals. In 1993, the "private financing initiative" for health care services was started by the government, within which private companies could appeal for the right to build and manage public hospitals. Not very many contracts of this type were concluded. In terms of health care, the United Kingdom is close to a developing country (the necessity of creating waiting lists of people set up for treatments, more strict criteria for directing to operations, e.g. most of the NHS regional management offices refuse covering the costs of in vitro sessions). Physicians generally do not direct +75 patients and those seriously ill for expensive operations like inserting a hip joint endoprosthesis or dialysis. This is why about 14% households in the United Kingdom bought health care insurance policies in private companies, making them independent of NHS services. Under these circumstances, the government must highly increase the NHS budget or apply major saving cuts. Either of these solutions will be a "bitter medicine". So far, only queues of patients waiting for operations got reduced, which is the consequence of the government introducing permits for the hospitals to pay boni to the most efficient surgeons. With this decision, salaries of surgeons in NHS increased by 100%. The fact is, however, that public health care services in the United Kingdom are closer to financial breakdown than ever before. Clearly, no-one thinks about liquidation of the National Health Service which has been active for 50 years. With the basic services, such as obstetrics and ambulance services, NHS acquits itself very well. In recent years, certain fees have been introduced in the United Kingdom for some medical services, such as writing out prescriptions (the fee for each one is £6.20), optical and dentist services, the fees are collected for the benefit of NHS, but it is very difficult to find a dentist willing to work for NHS, thus more and more people take private dentist services. Patients receiving state-funded benefits and OAPs and pensioners are exempt from these fees (1; 2; 7; 11).

In France, where the 1996 deficit of the public health care service was ca USD 10 bn, the government wanted to set up a no-pass limit for health care. The difference between the limit and the actual expenditures would have to be covered by physicians from their income. The objective of this solution is reduction in the number of visits to physicians and the treatment recommended by them. Thousands of physicians went on strike against such decisions in November 1996, cancelling all visits

for the coming four days. This resulted in the government starting mitigation of its initial plans. On 16 June 2004, the French government adopted a package of changes in the health care system. The reform was aimed at reduction of the deficit in public funds for health care, estimated at present at ca EUR 13 bn. One of the elements of the reform was introduction of EUR 1 lump-sum fees for each visit to a physician. Moreover, the whole medical documentation was converted into IT systems and the principles of drug refunding were changed to promote cheaper generics. The changes, which directly affected the patients, are the necessity of acquiring referrals from a family physician before visiting a specialist and the obligation of paying EUR 1 for each visit to a physician (11).

In Italy, prices were reduced (by 12%) for the medicines whose purchases are in part regulated by the state budget. Additionally, it was proposed that physicians hired in the public health care could earn additionally with receiving private patients if they agree to 15% reduction in salaries.

In the Netherlands, the health care services could not be left “in the hands of the market”, as it would cause high increase in costs. However, at present the Netherlands cannot afford to maintain social care centres. Reorganisation of the structure of health care services is also planned. The objective is, among others, to make old-age people stay at their homes as long as possible with the help of a nurse coming for 20 hours per week. The group with no medical indications, which would need care as they cannot take care of themselves, will be directed to the intermediate health care sector and will be obliged to partial participation in costs. It means forcing the patient to make payments so that he is aware of the cost of his/ her care. Health care insurance does not apply to cosmetic treatment, as it is paid by the interested persons themselves. In the Netherlands, each region has its own system of medical services which creates the so-called net, i.e. clinic hospitals, daytime care facilities, psychiatry, paediatrics, etc. It is the patients who decide how many physicians are necessary in the given area (region). However, this is experience of many years. The most important in this system is the family physician (the central figure). The patient is referred to specialists only and solely by the family physician. The information about writing out a referral is entered into the patient’s file (10).

It follows from the above that the problem throughout Europe comes in permanently increasing treatment costs. Health care needs an injection of cash to cover the expenditures which are not covered in the budget, otherwise it will have to limit the services provided. This situation of shortage of financial funds makes the situation of physicians and patients a difficult one. Therefore, almost each country ponders about plans of reorganisation of the system or imposition of limits on expenditures related to medical care, withdrawing from very expensive therapeutic methods, as well as closing down some medical facilities. However, real changes may occur as a result of development of privatisation in the competition. The United Kingdom has gone farthest in this direction. Germany and the Netherlands have also made their first attempts. France and Italy, as well as Poland, are at the stage of preliminary reform steps.

Table 1 presents the data related to health care expenses in selected European countries in the years 1999–2003.

Table 1

Expenditures for health care in the years 1999–2005 in selected European countries as % GDP

Country	1999	2000	2001	2002	2003	2004	2005	2008
Austria	8.1	8.0	7.7	7.5	7.5	9.6	10.2	10.5
Belgium	8.7	8.7	9.0	9.1	9.6	10.1	10.3	10.2
The Czech Republic	7.2	7.2	7.3	7.2	7.5	7.3	7.2	7.1
Denmark	8.5	8.3	8.6	8.8	9.0	8.9	9.1	9.7
Finland	6.9	6.6	7.0	7.2	7.4	7.5	7.5	8.4
France	9.4	9.5	9.5	9.7	10.1	10.5	11.1	11.2
Germany	10.7	10.6	10.7	10.9	11.1	10.9	10.7	10.5
Greece	8.7	8.3	9.4	9.8	9.9	10.0	10.1	9.7
Hungary	6.8	6.8	6.8	7.8	8.4	8.3	8.1	7.3
Ireland	6.8	6.7	6.5	7.3	7.4	7.1	7.5	8.7
Italy	7.8	8.1	8.4	8.4	8.4	8.4	8.9	9.1
Luxembourg	6.0	n/a	5.6	7.2	6.9	8.0	8.3	7.2
The Netherlands	8.2	8.1	8.9	9.3	9.8	9.2	9.2	9.9
Norway	8.8	7.8	8.3	9.9	10.3	9.7	9.1	8.5
Poland	6.2	6.1	6.3	6.6	6.5	6.5	6.2	7.0
Portugal	8.4	8.2	9.2	9.3	9.6	10.0	10.2	9.9
Slovakia	5.8	5.9	5.7	5.7	5.9	5.9	7.1	7.8
Spain	7.7	7.7	7.5	7.6	7.7	8.1	8.2	9.0
Sweden	n/a	n/a	8.7	9.2	9.4	9.1	9.1	9.4
The United Kingdom	7.1	7.3	7.6	7.7	n/a	8.3	8.3	8.7

Source: (4; 6; 5).

The data in Table 1 show that the largest share of the total expenses for health care, calculated as GDP interest, is in Germany (in 2005 and 2008 in France), with the smallest share of these expenses in Slovakia, but as early as in 2005 a noticeable increase up to the level of 7.1% GDP was apparent, and in 2008: up to the level of 7.8% of GDP. The share of expenses for health care was systematically increasing in Norway up to 2003, with the following decrease; and the share of expenses for health care has been at a fixed level since 2001 in Italy and, with slight increase, in Hungary and in the United Kingdom. In Poland, the total expenditures are almost unchanging, e.g. in 2003 and 2004 they constituted 6.5% GDP, in 2005: 6.2% GDP; increasing in 2008 up to 7.0% of GDP. The above analysis of shows that Poland is one of these EU countries which spend the least amounts for health care (these are Luxembourg, Poland and Slovakia, although the situation in 2005 changed). Thus, Poland stands quite weak among the selected EU countries, and its competitiveness against other countries is negligible and in 2005, simply none (Poland ranks last this year). Poland,

among the EU countries, is one of these countries which allocate the least amount of funds for health care.

4. Conclusions

With the above analysis, the following conclusions come:

1. At present, ever increasing costs of treatment are the problem in all European countries.
2. Throughout Europe, changes are made on protection of health. The objective of the reforms is to reduce the deficit of public funds for health care.
3. The market in the health care systems is a non-reliable mechanism, which leads to worsening of its effectiveness and quality. That is why intervention is necessary in it, as it is done in many countries, e.g. Germany, the Netherlands or France.
4. The private sector in all the countries has been developing. Moreover, it is expected that European health care systems may be fully privatised.

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Polityka zdrowotna w Polsce i w wybranych krajach Unii Europejskiej. Próby zredukowania szybko rosnących kosztów leczenia

Streszczenie: Celem opracowania jest omówienie systemów opieki zdrowotnej w wybranych krajach. W artykule zaprezentowano cztery podstawowe modele służby zdrowia, to jest

model Bismarcka, model Beveridge'a, model rezydualny oraz model Siemaszki. W dalszej części przedstawiono informacje dotyczące deficytu służby zdrowia w Polsce, a także deficytu pojawiającego się w wybranych krajach europejskich, to jest w Niemczech, w Wielkiej Brytanii, we Francji, we Włoszech czy w Holandii. Podkreślono, że obecnie w całej Europie toczy się batalia o zredukowanie wydatków na służbę zdrowia bez drastycznego ograniczenia zakresu publicznych świadczeń zdrowotnych. Niedostatek środków finansowych i wciąż rosnące wydatki na opiekę medyczną stawiają w trudnej sytuacji nie tylko lekarzy, ale również pacjentów. Przedmiotem analizy jest wskazanie możliwości redukcji nadmiernych kosztów publicznej służby zdrowia, jednak bez drastycznego ograniczania zakresu publicznych świadczeń zdrowotnych. Podkreślono, iż rzeczywiste zmiany mogą jednak nastąpić na skutek rozwoju prywatyzacji konkurencji. W końcowej części pracy pokazano wydatki na ochronę zdrowia w latach 1999–2008 w wybranych państwach europejskich jako % PKB.

Sł o w a k l u c z o w e: publiczna służba zdrowia, deficyt, cięcia oszczędnościowe, świadczone usługi
