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DIVERSITY OF PUBLIC EXPENDITURES ON HEALTH CARE IN SELECTED EUROPEAN UNION COUNTRIES IN THE YEARS 1990–2002

1. INTRODUCTION

Sources of financing health protection vary in individual countries and systems and their character depends on a political choice made by the representatives of the societies. In the majority of highly industrialized nations the basic part of financial resources in the health care system comes from public sources which include general taxes and social insurance contributions. A smaller variable part of these resources comes from direct payments made by the patients or from additional insurance programs that the patients join on a voluntary basis.

Taking into account the above-mentioned facts, the basic aim of this study was to present the development of public expenditures on health care in Poland in the years 1990–2002 against the background of selected European Union member-states. The presented comparative analyses did not take into account two countries: Luxembourg and Greece. They are different form the remaining analyzed countries because in the health care their share of public expenditures in total expenditures is connected in the first place with the functioning system of health care. In Luxembourg the health care is financed in over 91% from public sources, while in Greece approximately 40% of the resources come from direct payments made by the patients. Thus it was expedient to specify the type of valid system, because in the process of conducting comparative analyses one should stick to the specificity of a given health care system.

Taking into account the existence of various mechanisms of financing health care that influence the character of health care systems, the paper will

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present a short characteristic of insurance systems functioning in selected European Union countries since they exert a huge impact on the functioning of the whole health care sector.

Presentation of the development of public expenditures on health care – either in terms of their share in the GDP or as a part of total expenditures earmarked for health care is aimed at picturing the existing tendency of these quantities in Poland and in selected European Union countries.

Information relating to the discussed quantities comes both from Health Data 2004 and from Statistical Bulletins of the Central Statistical Office. All data were given in USD per capita according to the Purchasing Power Parity.[1]

2. CHARACTERISTICS OF HEALTH CARE SYSTEMS IN SELECTED EUROPEAN UNION COUNTRIES

Individual European countries began to build systems of general protection of health services which showed either features of the Bismarck's or the Beveridge's system. In each case the systems were meant to provide both the most comprehensive access to the biggest number of services and financial protection of the sick.

However these two systems differ considerably and their properties play a decisive part in the process of shaping health protection policies in countries in which they are in force. The following features of these models (Table 1) are strengthened or weakened as a result of implemented transformations and reforms of the health care system.

In European Union member-states one can come across both insurance and budget systems. The countries where taxes constitute the basis of health care financing include: Denmark, Finland, Ireland, Greece, Italy, Portugal, Spain, Sweden and Great Britain. The countries in which resources coming from health or social insurance are the prevailing financing source include: Austria, Belgium, France, Germany, Luxembourg and the Netherlands. For the last couple of years the majority of European Union states have witnessed changes in the field of health care aimed at improving the already existing solutions. This has resulted in the emergence of systems which include elements of both the Bismarck's and the Beveridge's model.

[1] Purchasing Power Parity – PPP is currently used for the purposes of international comparisons. According to the theory of the PPP arbitration actions remove the differences in the (purchasing power) value of monetary units in individual states which result from the price differences in these countries.

Table 1. The most common financial models of health care in European countries

Bismarck's model	Beveridge's model
The resources come from contributions which are to a great extent obligatory and employment-related	The resources come from general taxes or other state resources
All contributors (mainly employees and their families) are eligible for receiving services.	Almost all citizens of the country are eligible for services
The funds are distributed by quasi-public non-profit organizations – sickness funds	The funds are distributed by central (government) or decentralized (government or local government) public administration institutions
„Service basket" determined by active exclusion of some types of services (i.e. stomatology or its part, physiotherapy, plastic surgery)	A very wide and general „service basket" determined in practice by public investments
Mainly private service providers who operate for profits (outpatient medical care) or non-profit service providers (hospitals)	Mainly public service providers
Contracts between the payees and service providers	The resources are allocated from the central to the intermediate level (including local governments) and to service providers according to the centrally determined rules
Contract rates determined through administration – negotiation mechanism, ofter uniform for the whole country	Allocation rules are determined centrally or on the regional level in relation to the infrastructure and population characteristics
Fee for service	Capitative financing and global budgets (mainly for hospitals)
Sharing the cost of the majority of services	Marginal share of the costs
Free choice of service provides, without the gatekeeper*	The "gatekeeper" function, regulated access to subsequent levels of the care

* Gatekeeper is a first-contact physician who refers the patients to other specialists and supervises the performance of all services for the patient in his custody.

Source: Own analysis on the basis of the works of A. Kozierkiewicz conducted in National Centre for Health Information Systems, Warszawa 2001.

In 1999 Poland introduced a system which could be called a budget-insurance one since it can be characterized both in terms of insurance and budget systems.

Taking into account the existence of various forms of organization and financing of health care in the European Union „old" countries, the next part of this study will discuss factors influencing expenditures on health care in selected countries which belong to the Community.

3. ECONOMIC CONDITIONS INFLUENCING PUBLIC EXPENDITURES ON HEALTH CARE

Apart from the insurance system existing in a given country, the health care expenditures are also influenced by the value of goods and services produced in the territory of the country.

The amount of investment outlays earmarked in the Gross Domestic Product for health care is a determinant of activities undertaken in this field of economy and of the allocation of financial resources for health care.

In the presented countries of the „old" European Union in the years 1995–2002 the GDP rose annually on average by 4.3%. Its biggest rise could be observed at the turn of the 1996/1997 (it amounted to 5.4%). In the years 2002 the GDP continued to rise, but its growth rate was much slower (2.5% – GDP expressed in USD *per capita*). In the year 2000 only in cases of Germany, Italy and Spain was the GDP growth lower than the average rate of changes of the gross domestic product for the European Union countries.

In the 1990s the GDP in Poland grew faster than the European Union average. However since 2000 this tendency has changed. In our country the GDP growth has become increasingly slower. Only the year 2002 was an exception as the one-basis index (2001 = 100) of the studied macroeconomic indicator amounted to 103.2% and was higher by 0.7% than the average GDP growth in the other analyzed countries (Table 2).

Table 2. Changes in the GDP levels in selected European Union countries in the years 1995–2002 (in %)

Country	1996	1997	1998	1999	2000	2001	2002
	previous year = 100						
Austria	104.3	102.4	104.3	104.3	104.6	102.6	101.4
Belgium	102.2	103.5	103.5	103.3	106.0	104.3	102.0
Denmark	104.8	104.8	103.5	105.7	104.3	103.8	100.1
Finland	104.3	109.3	107.3	101.9	107.2	103.8	100.9
France	103.3	105.1	104.0	103.4	104.3	105.7	102.6
Germany	103.5	101.9	103.1	103.5	103.5	102.0	101.6
Ireland	108.2	114.4	109.0	108.1	107.6	106.5	109.7
Italy	103.6	103.0	105.7	101.9	103.8	103.0	100.8
Holland	103.8	105.4	104.3	102.7	105.6	107.0	100.8
Portugal	103.0	105.8	106.5	106.5	104.8	104.0	103.2
Spain	104.4	104.8	106.6	106.6	102.4	104.2	103.5
Sweden	103.5	103.3	103.4	106.7	105.9	101.2	101.3
United Kingdom	104.2	107.7	104.0	103.2	104.9	105.7	104.6
Poland	108.4	107.6	106.1	104.3	104.3	102.9	103.2

S o u r c e: Own calculations on the basis of OECD Health Data 2004.

On the basis of this above table the average annual rate of changes in the GDP was determined in the years 1995–2002 according the following formula (1):

$$G = \sqrt[n-1]{\frac{y_2}{y_1} \cdot \frac{y_3}{y_2} \cdot \ldots \cdot \frac{y_{n-1}}{y_{n-2}} \cdot \frac{y_n}{y_{n-1}}} = \sqrt[n-1]{\frac{y_n}{y_1}} \quad (1)$$

where:

y – the level of the phenomenon in the period t, t = 1 … n, G – geometric mean.

In the years 1995–2002 the GDP in Poland rose annually on average by 5.24%.

Table 3. The dynamics of the GDP in Poland in the years 2003–2006 (current prices)

Years	2003	2004	2005	2006
Previous year = 100	104.3%	108.6%	107.7%	108.4%

Source: Wiśniewski (2004, Tab. 5, p. 20).

On the basis of Table 3 and using the formula (1) the average annual rate of changes was determined for the years 2003–2006. The results showed that the rate should increase to 7.24% in the years 2002–2006.

The conducted research show that one can expect a faster growth in GDP in the next four years. In four years, i.e. in the year 2006 the dynamics of the GDP growth should be similar to that of 10 years ago.

Proportions of individual sources of expenditures in each country differ a lot. According to a general rule which characterizes the health care expenditures, the highly industrialized nations can boast a higher share of public expenditures in the total expenditures on health care than the developing countries. Among highly industrialized countries one should mention Denmark and Great Britain. In these countries over 81% of all resources earmarked for health care come from public sources. In countries like Sweden or France this percentage oscillates between 76% and 78%.

Health care was financed exclusively from taxes in Denmark, Sweden, Italy and Spain, while health insurance was the basic source of obtaining funds for health care in France, Germany and the Netherlands.

The Netherlands has the smallest amount from taxes and health insurance contributions allocated for health care.

Table 4. Expenditures on health care according to financing sources in the year 2000 in selected European Union countries (in %)

Country	Taxes	Health (social) insurance	Direct financing	Private insurance	Other private fund
Austria	27.2	42.5	18.6	7.0	4.7
Belgium	12.7	58.5	16.0	2.0	10.8
Denmark	82.1	0.0	16.4	1.5	0.0
Finland	59.8	15.3	20.6	3.0	1.3
France	2.4	73.6	10.2	12.7	1.1
Greece	35.0	20.5	37.4	2.2	4.9
Spain	69.9	0.0	26.2	3.5	0.4
Holland	4.0	63.5	8.6	23.9	0.0
Ireland	66.0	9.8	11.0	5.6	7.6
Luxemburg	8.4	83.5	6.7	1.4	0.0
Germany	6.2	68.9	10.6	12.5	1.8
Portugal	66.1	5.1	19.6	1.6	7.6
Sweden	77.3	0.0	22.7	0.0	0.0
United Kingdom	71.9	9.1	10.6	3.2	5.2
Italy	73.7	0.0	22.9	0.9	2.5

Source: Niżnik (2004, p. 126).

Apart from the mechanisms of financing health services functioning in all analyzed countries in health care, the majority of funds comes from public resources.

4. PUBLIC EXPENDITURES ON HEALTH CARE IN SELECTED EUROPEAN UNION COUNTRIES IN THE YEARS 1990–2002

Proper management of health care finances requires conducting various analyses of the health care sector in terms of i.e. international comparisons.

The level of expenditures on health care is closely connected with the level of Gross Domestic Product (GDP) per capita in a given country. The size of GDP reflects the economic potential of a given country and the level of the wealth of the society. It also provides information on the amount of resources which could be used for individual and collective consumption and for investments in a given year. Germany is a European country (member of the "old" European Union) with the highest amount of health care expenditures calculated as percentage of the GDP, while Ireland has the smallest share of public expenditures on health care in the GDP percentage in terms of ways of financing of health services (Table 5).

Table 5. Percentage of GDP earmarked for health care in selected European Union countries in the years 1995–2002

	Country	Years							
		1995	1996	1997	1998	1999	2000	2001	2002
The share of total health expenditures in % GDP	Austria	8.2	8.3	7.6	7.7	7.8	7.7	7.6	7.7
	Belgium	8.7	8.9	8.6	8.6	8.7	8.8	9.0	9.1
	Denmark	8.2	8.3	8.2	8.4	8.5	8.4	8.6	8.8
	Finland	7.5	7.6	7.3	6.9	6.9	6.7	7.0	7.3
	France	9.5	9.5	9.4	9.3	9.3	9.3	9.4	9.7
	Germany	10.6	10.9	10.7	10.6	10.6	10.6	10.8	10.9
	Ireland	6.8	6.6	6.4	6.2	6.3	6.4	6.9	7.3
	Italy	7.4	7.5	7.7	7.7	7.8	8.1	8.3	8.5
	Holland	8.4	8.3	8.2	8.1	8.2	8.2	8.5	9.1
	Portugal	8.2	8.4	8.5	8.4	8.7	9.2	9.3	9.3
	Spain	7.6	7.6	7.5	7.5	7.5	7.5	7.5	7.6
	Sweden	8.1	8.4	8.2	8.3	8.4	8.4	8.8	9.2
	United Kingdom	7.0	7.0	6.8	6.9	7.2	7.3	7.5	7.7
	Poland	5.4	5.8	5.6	5.5	5.9	5.6	6.0	6.1
The share of public health expenditures in % GDP	Austria	5.8	5.8	5.3	5.4	5.4	5.4	5.2	5.4
	Belgium	6.0	6.4	6.0	6.0	6.2	6.2	6.4	6.5
	Denmark	6.8	6.8	6.8	6.9	7.0	6.9	7.1	7.3
	Finland	5.7	5.8	5.5	5.3	5.2	5.0	5.3	5.5
	France	7.3	7.2	7.1	7.1	7.1	7.1	7.2	7.4
	Germany	8.5	8.8	8.5	8.3	8.4	8.3	8.5	8.6
	Ireland	4.9	4.7	4.8	4.7	4.6	4.7	5.2	5.5
	Italy	5.3	5.4	5.6	5.6	5.6	6.0	6.3	6.4
	Holland	6.0	5.5	5.5	5.6	5.7	5.6	5.3	5.4
	Portugal	5.1	5.5	5.6	5.6	5.9	6.4	6.6	6.5
	Spain	5.5	5.5	5.4	5.4	5.4	5.3	5.4	5.4
	Sweden	7.1	7.3	7.1	7.2	7.2	7.2	7.5	7.9
	United Kingdom	5.8	5.8	5.5	5.5	5.8	5.9	6.2	6.4
	Poland	4.1	4.4	4.1	3.9	4.2	3.9	4.3	4.4

S o u r c e: Own analysis on the basis of OECD Health Data 2004, Statistical Bulletins of the Central Statistical Office 1991–2003.

Research into the relations of public health expenditures with the gross domestic product show that of all presented countries Germany, Sweden, France and Denmark take the lead. Their advantage is considerable and it amounts to about 2 percentage points. The share of public health expenditures in the GDP in Poland differs considerably from the share of these expenditures in the Gross

Domestic Product in the analyzed countries. While conducting the analyses one should however take into account the economic situation of the analyzed countries and especially the standard of living of their inhabitants.

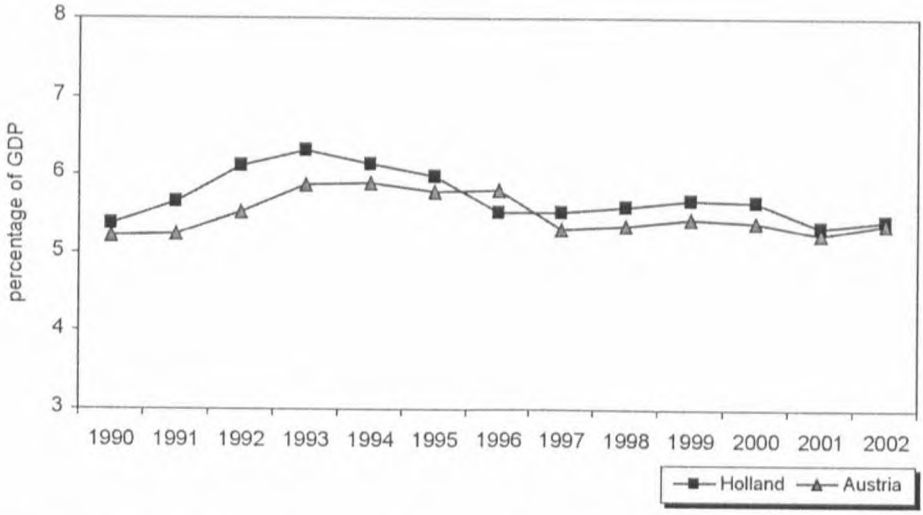

Fig. 1. Share of public expenditures on health care in % GDP in two selected European Union countries with insurance system of health care in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004.

Among presented here countries with the highest value of the gross domestic product per capita one can see a distinct downward tendency in the share of public expenditures on health care in the GDP. The tendency is the most conspicuous in the Netherlands where health services are increasingly financed both from the patient's pocket and by private insurance systems. Financing health care from public resources has increased slightly (the most in Austria by 0.14 percentage point in the year 2000 compared to the previous year) in the Netherlands and Austria since 2001.

In the whole analyzed period the share of public expenditures on health care in the gross domestic product in the remaining countries with insurance system of this field of economy was growing. This share is the biggest in Germany (over 8% in 1992) where in the years 1990–1996 public resources played in an increasingly important role in financing health protection. In the subsequent years (especially 1997–1998) the analyzed share decreased and then began to rise again in the year 2001. In Belgium in the years 1990–2002 the outlays for health care rose systematically (except for the year 1996 when they surged to the level of 6.38% of GDP). Still they did not exceed the level of 6.5%. Before 1996 and after 2001 the share of public expenditures on health care in the GDP rose also in France, although not so dramatically as in other countries.

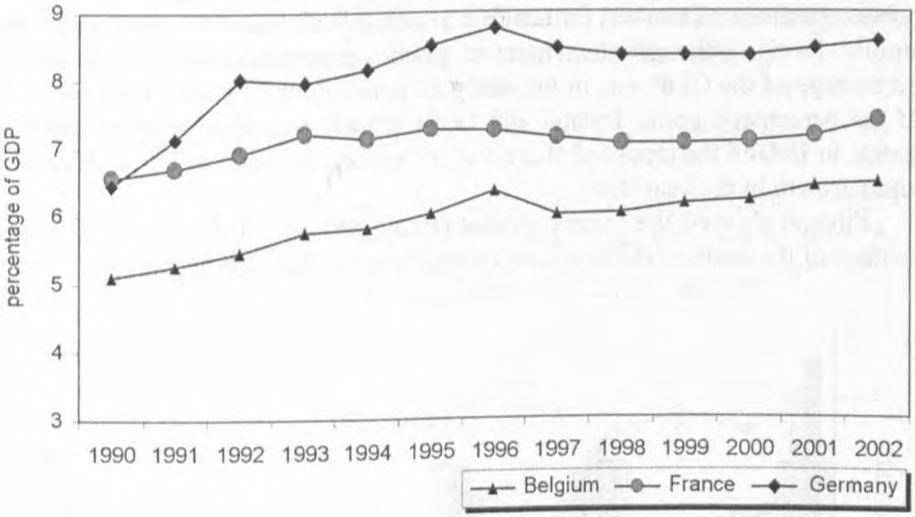

Fig. 2. The share of public expenditures on health care in % GDP in selected European Union countries with insurance system of health care in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004.

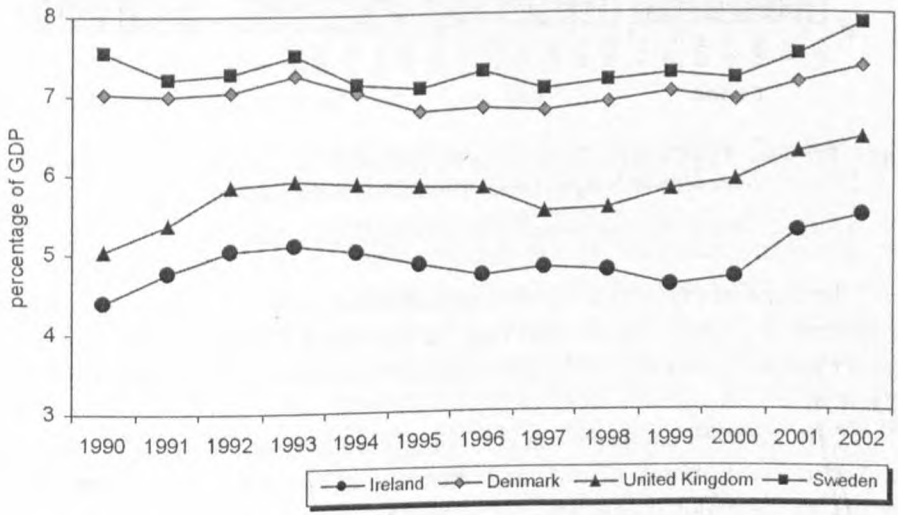

Fig. 3. Share of public expenditures on health care in % GDP in selected European Union countries with budget system of health care in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004.

Sweden takes the lead (7.88% of the share in GDP) among countries where public resources earmarked for health care come from taxes. Denmark can boast similar levels, although the share of public expenditures calculated as the percentage of the GDP was in the analyzed period lower by approximately 0.03 of the percentage point. Ireland and Great Britain constitute another group of states. In Ireland the analyzed share did not exceed the level of 5.5%, despite its rapid growth in the year 2001.

Finland showed the longest period (from 1991 to 2000) of fall of the percentage of the share of the analyzed expenditures in the GDP (Figure 4).

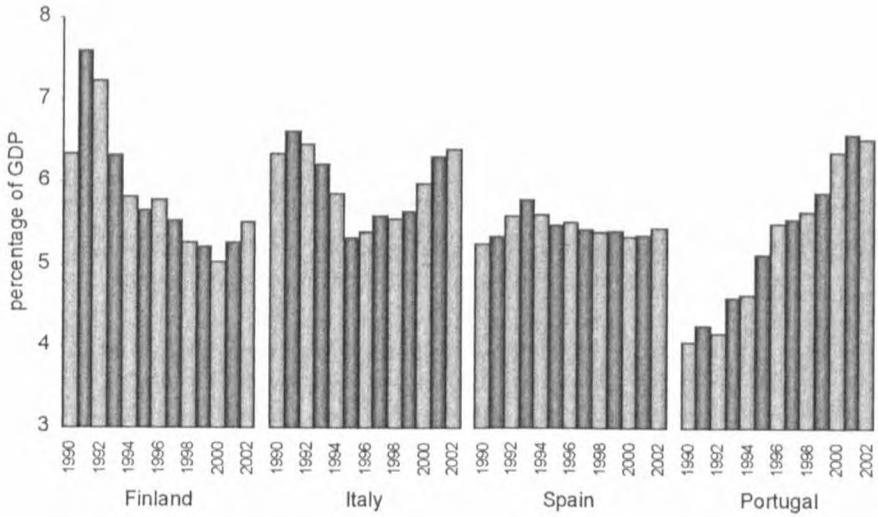

Fig. 4. The share of public expenditures on health care in % GDP in four selected European Union countries with budget system of health care in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004.

The share of the total and public expenditures on health care in % GDP runs in Poland at a much lower level than in individual European Union member-states (Strzelecka 2004b). Poland comes last in comparison with these countries (Table 5).

In all analyzed countries one can observe a systematic decrease of the share of public expenditures in the final outcome of the activity of all economic entities of the national economy (expressed in percentages). In Poland throughout the analyzed period one could notice some fluctuations in the development of current expenditures in % GDP. However in the whole analyzed period the expenditures showed a downward tendency. In our country one has been able to observe a growth of the share of investment expenditures in % GDP since the second research year (1991). The years 1990 and 1997 were an exception

because at that time this share rose considerably to the level of 8.2%. These changes can be explained by transformations taking place in the Polish economy and by the introduction of the health care reform in the year 1999.

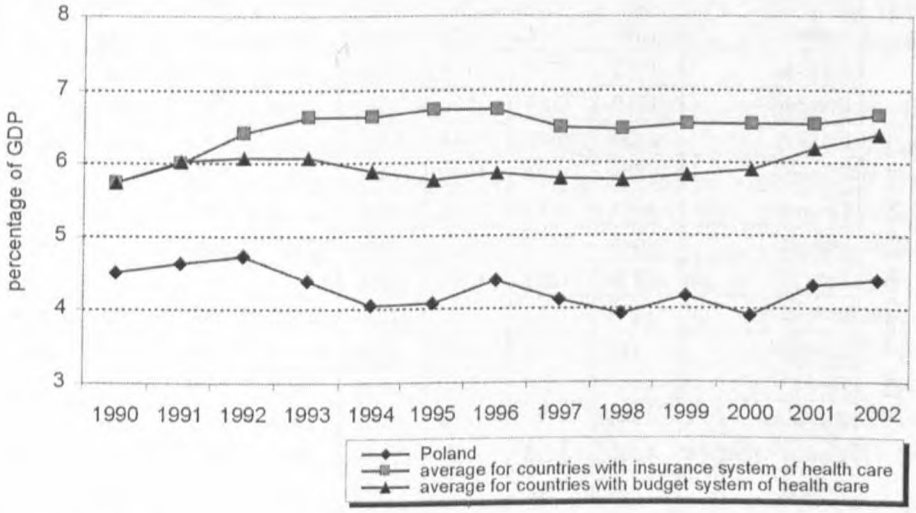

Fig. 5. The share of public expenditures on health care in % GDP in European Union countries and in Poland in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004, Statistical Bulletins of the Central Statistical Office 1991–2003.

When analyzing the development of the share of public expenditures on health care in % GDP in Poland one can say that it showed a downward tendency from the first research year to the year 2002. On average in the whole analyzed period the share of public expenditures in the final outcome of the activities of all entities of the national economy in Poland was lower in comparison with the countries with the insurance system of health care by about 2.2 percentage points, and in comparison with countries with the budget system of health protection by approximately 1.7 percentage points. In the last two analyzed years public expenditures on health care rose compared with the previous period, but the rate of this growth decreased. In the year 2001 it amounted to 14%, and one year later to only 5%. One year after the transition from budget financing to insurance financing public expenditures in our country fell by about 2.06%.

Presentation of expenditures on health care in fixed prices is aimed at picturing real changes and at showing levels of these quantities in all analyzed aspects. These data are included in Table 6.

Table 6. Expenditures on health care in USD per capita according to the PPP in selected European Union countries in the years 1995–2002, fixed prices from the year 1991

	Country	Years							
		1995	1996	1997	1998	1999	2000	2001	2002
The total health expenditures	Austria	1690	1748	1626	1701	1767	1746	1701	1742
	Belgium	1739	1794	1747	1794	1863	1934	2003	2050
	Denmark	1719	1783	1819	1882	1960	1948	2049	2083
	Finland	1333	1401	1445	1455	1471	1464	1541	1633
	France	1871	1894	1940	1981	2027	2082	2187	2276
	Germany	1973	2080	2044	2069	2126	2147	2159	2170
	Ireland	1095	1127	1234	1269	1359	1401	1549	1804
	Italy	1278	1294	1348	1395	1408	1476	1509	1494
	Holland	1639	1652	1670	1704	1739	1767	1882	2025
	Portugal	848	874	911	936	1013	1084	1104	1082
	Spain	974	980	988	1033	1083	1060	1070	1086
	Sweden	1540	1624	1629	1708	1828	1916	1965	2027
	United Kingdom	1250	1273	1298	1320	1389	1438	1541	1735
	Poland	126	121	110	103	106	96	101	93
The public health expenditures	Austria	1198	1217	1138	1186	1231	1216	1166	1217
	Belgium	1208	1276	1220	1260	1314	1363	1431	1459
	Denmark	1419	1469	1496	1543	1612	1607	1692	1730
	Finland	1007	1062	1100	1110	1108	1100	1163	1235
	France	1428	1442	1479	1506	1542	1580	1660	1730
	Germany	1588	1676	1618	1627	1671	1691	1698	1704
	Ireland	784	805	920	971	989	1027	1171	1356
	Italy	923	930	972	1002	1017	1088	1147	1130
	Holland	1165	1093	1132	1169	1198	1221	1173	1204
	Portugal	531	571	598	628	684	753	779	763
	Spain	703	709	716	746	780	759	763	776
	Sweden	1335	1411	1398	1465	1567	1626	1667	1730
	United Kingdom	1048	1055	1043	1061	1120	1163	1279	1446
	Poland	95	92	81	73	75	67	73	67

Source: As same as Table 5.

In the analyzed countries of the „old" European Union Germany allocates the highest amount of health expenditures (both total and public) while Portugal and Spain followed by Finland, Ireland and Great Britain allocate the smallest amount.

In two countries (insurance model of health care) in which the choice of service providers is not regulated and the existence of the institution of the

„gatekeeper" i.e. the first-contact physician is not so much popular, public expenditures on health care (in USD per capita, fixed prices from the year 1991) do not show any rapid changes. In the whole analyzed period these expenses reached the average level of 1163.55 USD per capita in Austria and 1144.77 USD per capita in the Netherlands. In Germany in the years 2000–2002 these expenditures amounted to 1691.07 USD; 1698.11 USD and 1704 USD respectively (fixed prices from the year 1991).

On the basis of these above data one can say that in countries with the budget system of health care, throughout the analyzed period public expenditures rose only in countries with the highest levels of GDP per capita – Ireland, Denmark, United Kingdom, Sweden. In other countries with group (Finland, Italy, Spain, Portugal) this tendency can only be observed in Portugal where public expenditures on health care in the whole analyzed period did not exceed the amount of 780 USD per capita, although financing from public resources reached increasingly higher levels and rose systematically from 458 USD per capita in 1992 to 779 USD per capita in 2001. In Portugal only the year 2002 witnessed a drop (763.03 USD per capita).[2] In Spain the discussed expenses oscillated in the last two research years (2001–2002) around 770 USD per capita.[3]

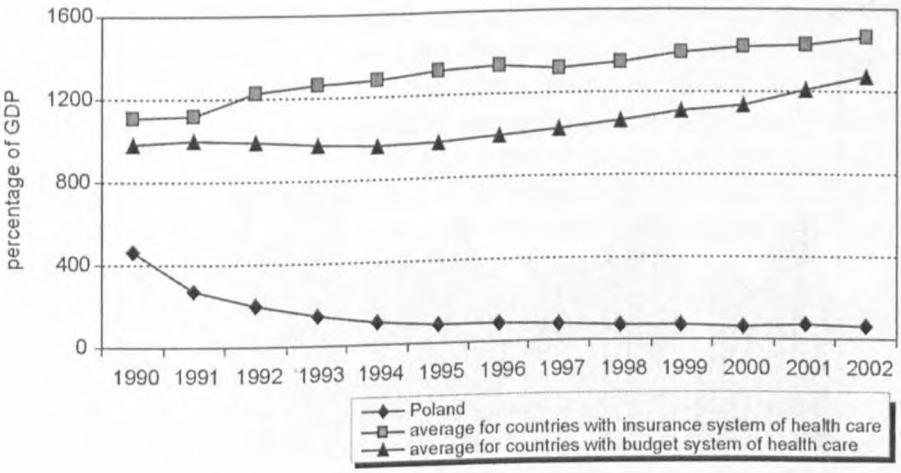

Fig. 6. Development of public expenditures on health care in European Union countries and in Poland in the years 1990–2002, fixed prices from the year 1991

S o u r c e: Own analysis on the basis of OECD Health Data 2004, Statistical Bulletins of the Central Statistical Office 1991–2003.

[2] Fixed prices form the year 1991.

[3] Fixed prices form the year 1991.

Considering the expenditures on health care in USD per capita according the purchasing power parity one can say that in Poland one allocates much less expenditures for health than in the analyzed European Union countries. The obvious conclusion from the data included in Table 6 is that public expenditures in the field of health care expressed in USD per capita according to the purchasing power parity are much higher in European Union countries than in Poland. Taking into account the development of health expenditures one can say that Poland finances health care at a very low level.

Considering the development of public expenditures on health care per capita in USD according to the PPP one can say that throughout the analyzed period public expenditures in Poland showed, in contrast to the average of the countries where health care is financed mainly from taxes and to the average of the countries where health care is financed mainly from contributions, a downward tendency.

In the majority of countries public expenditures constitute a considerable percentage of the total expenditures on health care. This paper has already mentioned that according to a general rule characterizing health care expenditures, the share of public expenditures in the total expenditures in this field of economy is higher in highly industrialized countries compared to the developing countries.

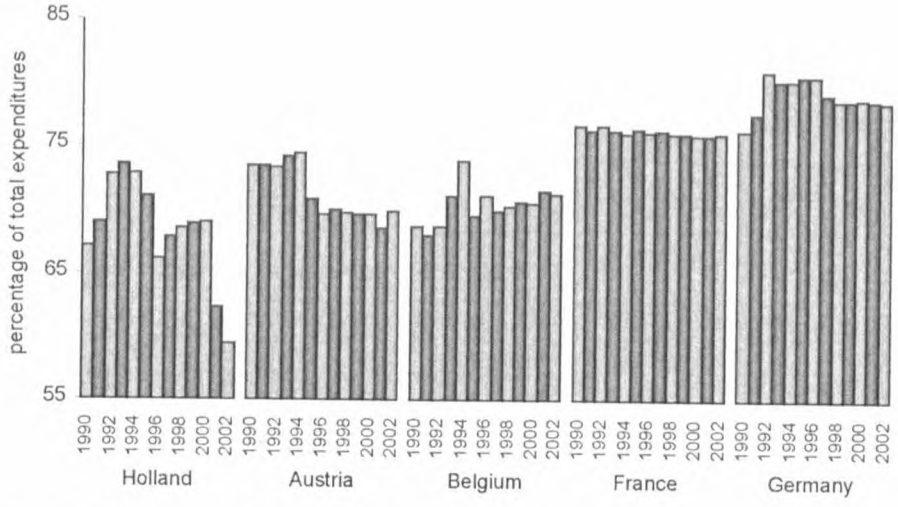

Fig. 7. Share of public expenditures on health care in the total expenditures on health care in selected European Union countries with insurance system of health care in the years 1990–2002

Source: Own analysis on the basis of OECD Health Data 2004.

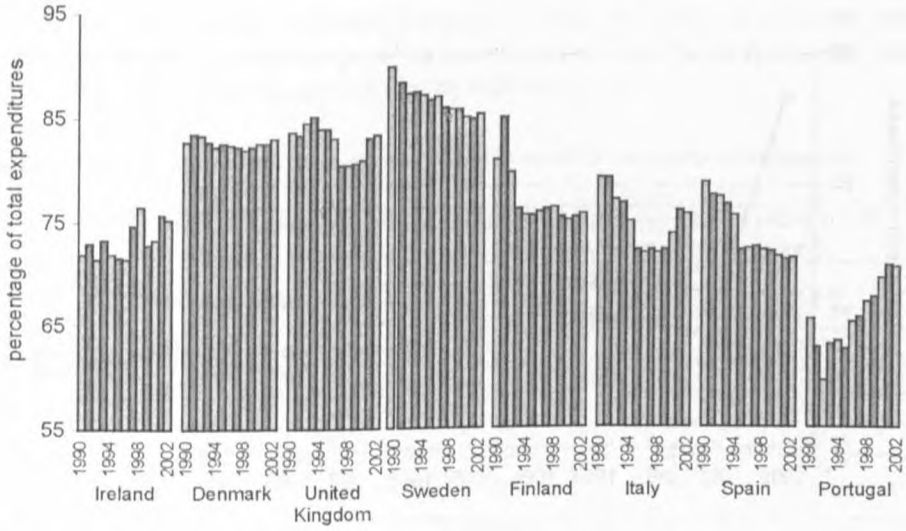

Fig. 8. Share of public expenditures on health care in the total expenditures on health care in selected European Union countries with budget system of health care in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004.

One can draw the following conclusions from the conducted analyses: in the analyzed period in countries with the Beveridge's model of the health care system Sweden (over 85%) and Great Britain (about 83%) were the countries with the highest percentage of public financing in the year 2002, but even there more and more private funds are being allocated to health care. Among countries with the Bismarck's model of health care the highest amount of public sources is allocated for health care in Germany (over 79%) and France (about 76%) and the smallest amount in Portugal and Spain (about 71%).

When analyzing the development of public expenditures on health care in Poland and their share in the total expenditures on health care one say that except for the year 1990 (system changes) the percentage of public expenditures in the total expenditures in our country is lower than in the countries belonging to the European Union that do not have the health care system adopted by Poland in 1999. The analyzed average share in the analyzed countries with the insurance model of this field of national economy and in Poland was at a similar level (71.5%) one year after Poland had introduced the Public Health Insurance (Figure 9).

Conclusions from the conducted analyses boil down to the statement that public expenditures on health care rise in comparison with the previous period, but the growth rate decreases.

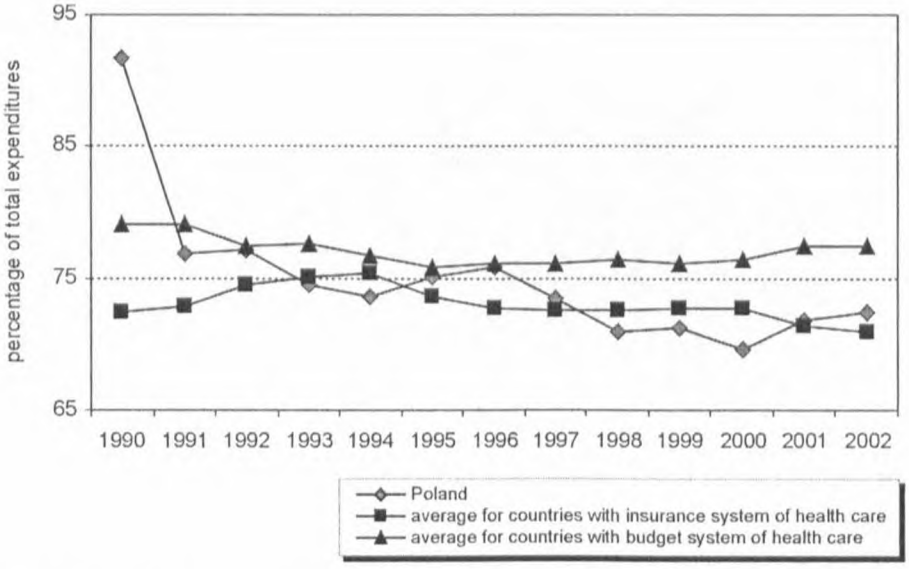

Fig. 9. Share of public expenditures on health care in the total expenditures on health care in the European Union countries and in Poland in the years 1990–2002

S o u r c e: Own analysis on the basis of OECD Health Data 2004, Statistical Bulletins of the Central Statistical Office 1991–2003.

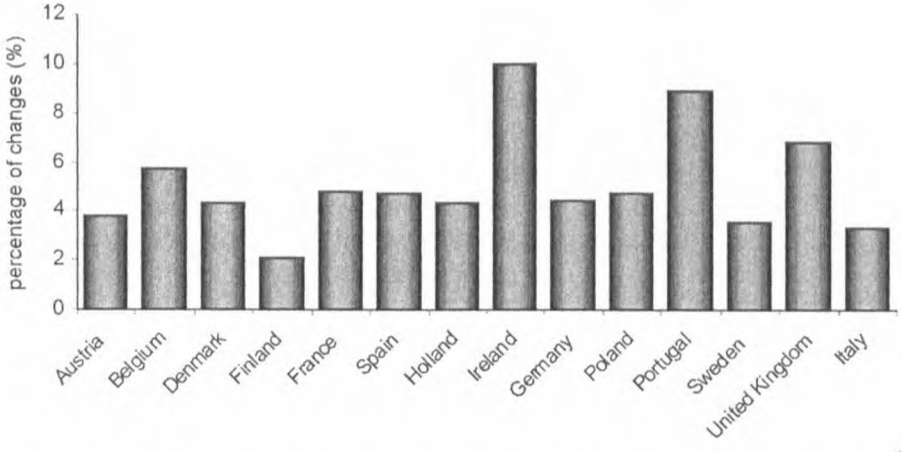

Fig. 10. Changes in the development of the amount of public expenditures on health care in selected European Union countries in the years 1990–2002 (in percents, current prices – USD per capita, PPP)

S o u r c e: Own analysis on the basis of OECD Health Data 2004.

On the basis of the presented research into the development of health care expenditures one can say that in all countries mid-year analyzed quantities rose. It is confirmed in the data included in the following table:

Table 7. Changes in the development of basic economic quantities in selected EU countries

Country	Average rate of changes in the expenditures on health care and GDP in the years 1990–2002 (in percentages, current prices)		
	Expenditures on health care		GDP
	total	public	
Austria	104.3	103.8	103.6
Belgium	105.4	105.7	103.6
Denmark	104.3	104.3	104.0
Finland	102.7	102.1	103.3
France	104.8	104.8	103.7
Germany	104.2	104.4	102.0
Ireland	109.6	110.0	108.0
Italy	103.7	103.3	103.2
Holland	105.3	104.3	104.2
Portugal	108.2	108.9	104.6
Spain	105.5	104.7	104.3
Sweden	104.0	103.6	103.2
United Kingdom	106.8	106.8	104.6
Poland	106.8	104.7	105.0

S o u r c e: Own calculations on the basis of OECD Health Data 2004.

Ireland could boast the fastest growth (10%) of public expenditures on health care per capita on annual basis throughout the analyzed period while Finland recorded the slowest growth rate (2.1%). In Poland this growth was at the level of 4.7%, in Portugal at 8.9% and in Great Britain at 6.8%.

5. CONCLUSIONS

Presentation of the development of public expenditures on health care in selected European Union countries allows one to spot some tendencies in the development of the analyzed economic quantities over the years 1990–2002.

The analysis conducted in this paper confirms the fact that the economic growth of a given country plays a huge role in the development of public expenditures on health care. The size of the GDP determines not only the wealth of the society but also the amount of expenditures for health care and especially

their part which is allocated by a given country for health care. As far as health care is concerned in European (Union) countries:

– France and Germany allocate the most total expenditures,
– Denmark, Sweden and France allocate the most public expenditures,
– Portugal and Spain allocate the least total and public expenditures.

Poland's entry into the European Union necessitates to some extent its adaptation to the new conditions and solutions applied in the former "EU-15" in every field of life. The comparisons of the development of public expenditures on health care in Poland and in selected countries of the Community should facilitate reforming this very important field of life. A low level of expenditures on health care in our country shows that in Poland not only the health care system should be improved, but also more attention should be paid to the economic growth, because on its basis one can spot not only the preferences of consumers of medical services and the wealth of the society but also determine the economic potential of the state. Poland's entry into the European Union can be regarded as a stage in the process of reforming health care. Reforming the current system of health care will not go far enough if Poland wants to provide its citizens with similar (or even the same) access to health care services. Verification of the level and types of provided health services is what's really needed in the first place.

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Agnieszka Strzelecka

ZRÓŻNICOWANIE WYDATKÓW PUBLICZNYCH NA OCHRONĘ ZDROWIA W WYBRANYCH KRAJACH UNII EUROPEJSKIEJ W LATACH 1990–2002

Środki finansowe przeznaczane na ochronę zdrowia są przede wszystkim uzależnione od potencjału ekonomicznego danego kraju. Wielkość PKB wpływa decydująco na wielkość wydatków na ochronę zdrowia, a szczególnie na tę jego część, która asygnowana jest przez dany kraj na opiekę zdrowotną. Różny poziom wzrostu gospodarczego czy istnienie odmiennych form ubezpieczeniowych i organizacyjnych w opiece zdrowotnej w poszczególnych krajach należących do Unii Europejskiej sprawia, iż widoczne jest duże zróżnicowanie wydatków publicznych na ochronę zdrowia pomiędzy tymi państwami.

Zatem podstawowym celem opracowania jest przedstawienie wydatków publicznych na ochronę zdrowia na przestrzeni lat 1990–2002 w Polsce na tle wybranych krajów członkowskich Unii Europejskiej.

Z uwagi na istnienie różnych mechanizmów finansowania świadczeń zdrowotnych, oddziałujących na charakter systemów ochrony zdrowia, w referacie zostanie ukazana również krótka charakterystyka systemów ubezpieczeniowych funkcjonujących w wybranych krajach Unii Europejskiej.

Informacje dotyczące omawianych wielkości pochodzą zarówno z bazy danych Health Data 2004, jak i z biuletynów statystycznych GUS.