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CHARACTERISTICS OF THE HEALTH CARE SYSTEM

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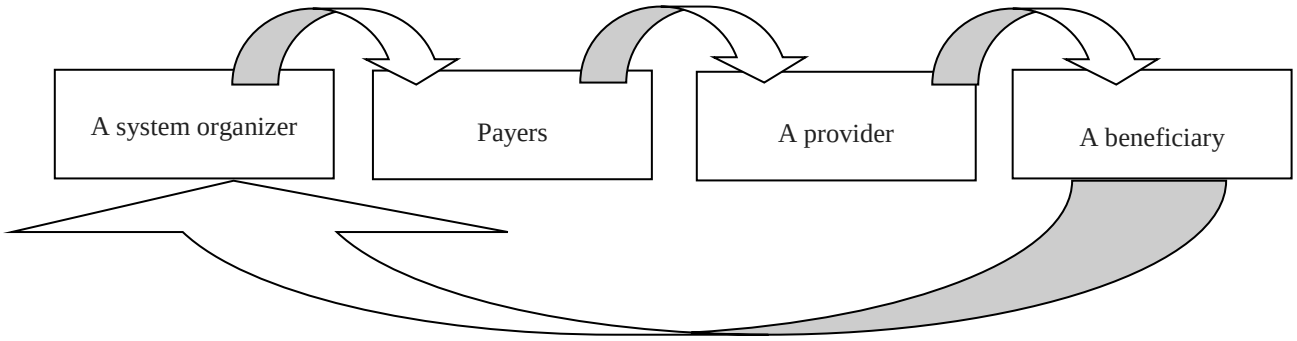
Abstract The purpose of this paper is to present the main data about the health care sector depends on how it is financed and thus the choice of an appropriate model healthcare system. The article shows a comparative analysis of health care systems in European countries of the OECD. Based on the literature, the general characteristics of Beveridge and Bismarck systems are presented. The evolution of the health care system in the world arises from a different history, conditions for economic development, diversity, under State policy, geographical location and cultural. Every country in the world takes part in the financing of health care, which is 20-80% of the expenditure on health. According to t. Szumlicza you must distinguish between concepts: "model" and "standard". The "formula" is understood in the context of the broader concept of "model of the health system". As the author of finding "patterns express different real concept of health policy while the term" pattern "prejudge the specific choice of health policy, which is a reference to the health care system".
The World Health Organisation defines the term "health system" as a system covering all organizations, investment and institutions whose concept is to create actions on improved health. According to the Organization's objectives is the basis for the operation of the system of health protection, which targets focus on: constant improving population health, meeting the demand needs of health services, where the recipient is you as a consumer. On the other hand, the term "health care" defined by the WHO as a program of benefits in accordance with medical knowledge necessary to promote and maintain health by sharing individuals and entire populations. C. Wlodarczyk stresses that for the proper definition of the concept of health system you must extract the three spheres of the impact of health policy: health, administrative institutions and finance health and traditional public health activities. Many definitions that appear in the literature points to the narrower scope of the definition of the concept of "health care system" than those WHO suggested.. Author B. McPake and colleagues present the thesis that the health system consists of payers, healthcare providers and regulatory bodies together with relationships that occur between them. These relationships are presented for four health system functions: regulatory, financial, allocation of resources and the provision of services. C. Bailey and S. Poździoch describe that the health system is a whole, consisting of a variety of elements, the associated affinity, between which there are relationships. S. Poździoch is used for the definition of the system: "organized and coordinated team actions, whose aim is the realization of benefits and services and awareness campaign-therapeutic and rehabilitation aimed at protection and improvement of the health status of the individual and the collective ". The fact is the large role played by the State in the health system.
Keywords: health care, public sector, models in health system

1. TYPES AND FUNCTIONING OF THE HEALTH CARE SYSTEM

The smooth operation of the health care sector largely depends on how it is financed , and thus the choice of an appropriate model healthcare system. Currently, there are three traditional models: Bismarck's model based on mandatory contributions of health, the Beveridge model based on state taxes and the model residual, which is characterized by voluntary, private health insurance. Until the 90s of the XX century were distinguished Siemaszko model based on central planning and financing of health services by the state budget. Moreover the Siemaszko`s model currently there is no certain elements are used. Adoption by the state specific model of health care financing entails a number of other consequences that are felt by all participants in the system not only patients, but also board/ directorate of medical institutions, and ministries of health[33].
The healthcare sector consists of companies that provide medical services, manufacture medical equipment or drugs, provide medical insurance, or otherwise facilitate the provision of healthcare to patients[34]. Organisation of health care systems is affected by solutions in terms of their use in Germany, the United Kingdom and the United States, which were considered precursory[35].

[33] K. Wielecka, *Zarys funkcjonowania systemów opieki zdrowotnej w wybranych krajach Unii Europejskiej,*Zeszyty Naukowe Politechniki Śląskiej, nr 1909, 2016 r.
[34] https://www.investopedia.com/terms/h/health_care_sector.asp, access: 16.05.2019 r.
[35] C. Wendt, L. Frisina, H. Rothgang *Healthcare system types: A conceptual framework for comparison.* Social Policy & Administration 2009, vol. 43, np. 1,

Figure 1 The process of organization of the health care system in Poland



Source: Author`s own elaboration.

The health insurance system in Poland consists of: a payer, which is the National Health Fund with headquarters in Warsaw, where the NFZ head office is located. It operates on the basis of the Act of 27 August 2004 on health services financed from public funds and the statute. At present, each province has a NFZ branch and is sixteen. The payer also specifies the state budget and budgets of local government[36]. The service provider within the meaning of the Act is:

- an entity performing medical activities within the meaning of the regulations on medical activity,
- a natural person who has obtained professional qualifications to provide health services and provides them as part of a business activity,
- entity performing activities in the field of supplying medical devices. The beneficiary within the meaning of the Act is an entity entitled to use health care services, while the organizers of the system are, at the central level, the government and parliament and, at the local level, local government units. Subsequent changes in the health care system were introduced by the Act of 1 July 2011 on therapeutic activity recognized as the fundamental legal basis for the functioning of entities carrying out medical activities in Poland. The Act introduced changes in the area of establishing and financing healthcare facilities in Poland. The basic principle included in the Act is that entities carrying out health care activities have the status of an entrepreneur. This change meant that new hospitals and clinics could only be established as companies, and local governments that do not convert Independent Public Complex of Health Care Facilities (SPZOZ – Samodzielny Publiczny Zakład Opieki Zdrowotnej) into companies will be required to cover their negative financial results within 6 months from the end of the date of approval of the financial statements. In relation with with the entry into force of the Act, the law of 30 August 1991 on health care institutions lost its force. The catalog of medical entities referred to in art. 4 of the Act is a closed catalog and entities that are not mentioned do not have the status of a medical entity[37].

2. HEALTH EXPENDITURE

Health spending measures the final consumption of health care goods and services (i.e. current health expenditure) including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments. Health care is financed through a mix of financing arrangements including government spending and compulsory health insurance ("Government/compulsory") as well as voluntary health insurance and private funds such as households' out-of-pocket payments, NGOs and private corporations ("Voluntary"). This indicator is presented as a total and by type of financing ("Government/compulsory", "Voluntary", "Out-of-pocket") and is measured as a share of GDP, as a share of total health spending and in USD per capita (using economy-wide PPPs)[38]. Gross Domestic Product (GDP) = final consumption + gross capital formation + net exports. Final consumption of households includes goods and services used by households or the community to satisfy their

[36] A. Przybyłka *Systemu ochrony zdrowia.* Prace naukowe Uniwersytetu Ekonomicznego w Katowicach, Katowice 2011 r., s. 105,

[37] A. Przybyłka *Systemu ochrony zdrowia.* Prace naukowe Uniwersytetu Ekonomicznego w Katowicach, Katowice 2011 r., s. 113.

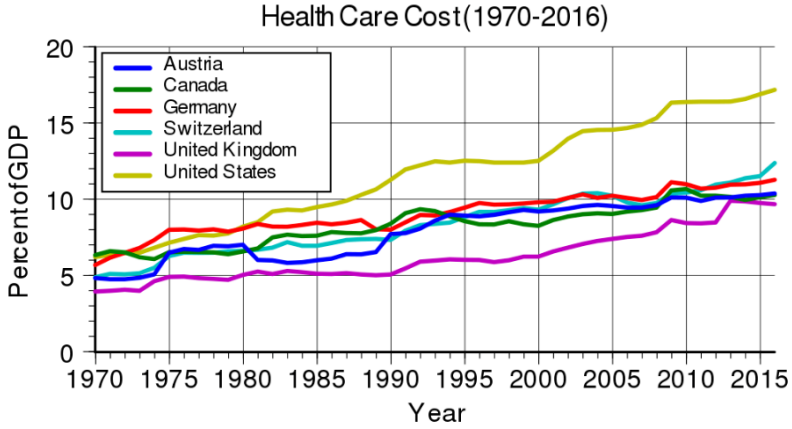
[38] https://data.oecd.org/healthres/health-spending.htm, access: 15.05.2019,

individual needs. It includes final consumption expenditure of households, general government and non-profit institutions serving households[39].

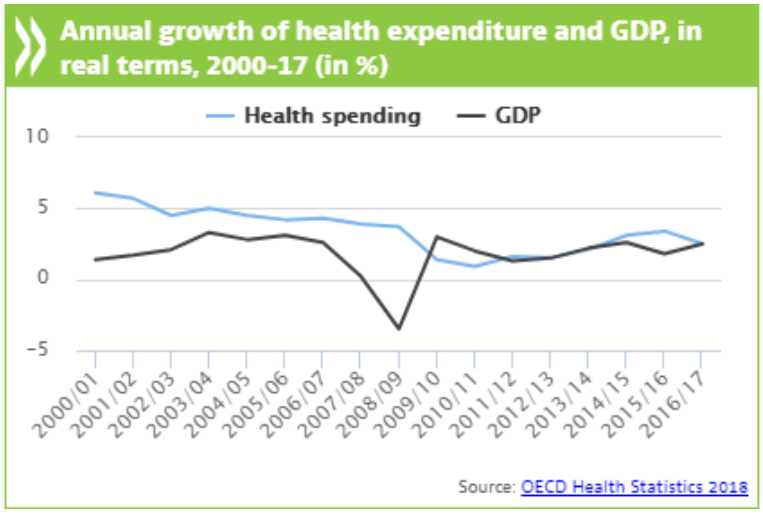
OECD spending on health care increased by 3.4%, on average, in 2016, the highest rate since 2009 although still below pre-crisis levels. Preliminary estimates for 2017 expect spending to keep growing but by less, at around 2.5%. The figures refer to what governments and individuals spent.

Health spending as a share of GDP was 8.9% in 2016 and is forecast to remain at this level in 2017. At 17.2% of GDP, health spending was highest in the United States, and significantly more than Switzerland (12.3%) and France (11.5%), the second and third highest spenders. At the other end of the scale, Turkey (4.2%) and Mexico (5.4%) each spent less than 6% of their GDP on health.

In per capita terms, health spending in 2017 is estimated to have reached USD 4 069 (adjusted for differences in price levels) on average across the OECD. This is roughly 70% more than OECD countries spend on education for each citizen. In the United States, the average spend is expected to have risen above USD 10 000 for the first time in 2017. Per capita spending was also significantly above the OECD average in Switzerland (USD 8 009), Luxembourg (USD 7 049) and Norway (USD 6 351).



Source: OECD[40].



Source: OECD.

[39]https://www.oecd-ilibrary.org/docserver/9789264090316-43-en.pdf?expires=1558199491&id=id&accname=guest&checksum=10811892DBEEB7E3C4B99268C8F049BB, access: 15.05.2019,

[40]Health expenditure and financing. OECD (Organisation for Economic Co-operation and Development). Choose options from dropdown menus, access: 10.05.2019.

Changes in the ratio of health spending to GDP are the result of the combined effect of growth in both GDP and health expenditure. Apart from Norway and Estonia, health spending per capita grew more quickly than GDP per capita between 1998 and 2008, resulting in an increasing share of the economy devoted to health in most countries Some European countries that experienced relatively strong economic growth over that period – such as the Slovak Republic, Ireland and Turkey – saw even greater increases in health spending resulting in large increases in the health to GDP ratio. Slovenia, the Czech Republic and Hungary also experienced relatively high economic growth, but health spending growth, although high, did not significantly outpace that of the overall economy resulting in only moderate increases in the health to GDP ratio[41].

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[41] https://www.oecd-ilibrary.org/docserver/9789264090316-43-en.pdf?expires=1558199491&id=id&accname=guest&checksum=10811892DBEEB7E3C4B99268C8F049BB, access: 10.05.2019.