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Financing of tasks in the area of public health in selected European Union countries and Norway

Finansowanie zadań z zakresu zdrowia publicznego w wybranych krajach członkowskich Unii Europejskiej i Norwegii

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Keywords

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Słowa kluczowe

wydatki na zdrowie, koszty opieki zdrowotnej, koszty i analiza kosztów, zdrowie publiczne

S u m m a r y

Introduction. After years of efforts of the scientific community, the public authority in Poland saw importance of public health and in 2015 it decided to enact the law on public health (LPH). The new act introduced a solution designed to provide maximization of the benefits of realization of tasks in the field of public health, among other things thanks to the new mechanisms and sources of financing.

Aim. In the context of the new legislative solutions in this paper the international comparative analysis of expenditures on public health tasks in selected EU countries and Norway was made.

Material and methods. In the comparative analysis, the OECD data for the years 2000-2014 was used. The analysis of the expenditures on health and tasks in the area of public health was carried out in total for 22 countries (21 EU Member States and Norway).

Results. In 2013, these expenses amounted to maximum 0.5% of GDP and ranged from 0.7% (Latvia) to 5.9% (Finland) of the total expenditures on health care. In Poland, it was nearly $ 1.5 billion, i.e. 0.2% of GDP, which accounted for 2.6% of the total expenditures on health care.

Conclusions. The amount of the expenditure on the tasks related to public health is very diverse in the EU countries, however in all countries included in this analysis their steady nominal growth is observed. It allows us to assume the increasing importance of public health in the European Union.

S t r e s z c z e n i e

Wstęp. Po latach starań środowiska naukowego władza publiczna w Polsce dostrzegła znaczenie zdrowia publicznego i w 2015 roku zdecydowano się na uchwalenie ustawy o zdrowiu publicznym. Nowy akt prawny wprowadza rozwiązania, mające zapewniać maksymalizację korzyści płynących z realizacji zadań z zakresu zdrowia publicznego, m.in. dzięki nowym mechanizmom i źródłom ich finansowania.

Cel pracy. W kontekście nowych rozwiązań legislacyjnych w Polsce, w niniejszej pracy dokonano międzynarodowej analizy porównawczej wydatków na zadania z zakresu zdrowia publicznego w wybranych krajach Unii Europejskiej i Norwegii.

Materiał i metody. W analizie porównawczej wykorzystano dane publikowane przez OECD za lata 2000-2014. Analizę wielkości wydatków na ochronę zdrowia oraz zadania z zakresu zdrowia publicznego przeprowadzono łącznie dla 22 krajów (21 państw członkowskich UE i Norwegii).

Wyniki. W 2013 roku w analizowanych krajach na zadania z zakresu zdrowia publicznego przeznaczano nie więcej niż 0,5% PKB, co stanowiło od 0,7% (na Łotwie) do 5,9% (w Finlandii) ogółu wydatków na ochronę zdrowia. W Polsce na zdrowie publiczne przeznaczono w 2013 roku blisko 1,5 mld USD, czyli 0,2% PKB, co stanowiło 2,6% ogólnych wydatków na ochronę zdrowia.

Wnioski. Wielkość wydatków na zadania z zakresu zdrowia publicznego jest bardzo zróżnicowana w krajach Unii Europejskiej, jednak we wszystkich krajach włączonych do analizy obserwuje się ich stały nominalny wzrost. Dzięki temu można założyć także wzrost znaczenia zdrowia publicznego w Unii Europejskiej.

Konflikt interesów
Conflict of interest

Brak konfliktu interesów
None

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INTRODUCTION

The State is responsible for carrying out of activities that are aimed at protection and improvement of the health of its citizens. In response to the task himfaced by it, the Ministry of Health has undertaken work on the development of the law on public health (LPH).

The effect of these works was presented on 17 March 2015 – The Ministry of Health published the draft of LPH then. It was argued that "the need for the preparation of the Act is primarily due to the need to establish mechanisms to achieve improvement in the health of the society. (...) There is no doubt that population health is a value in itself while a coherent and effective state policy in the field of public health in a fundamental way affects the functioning of the society. Good health of citizens is a prerequisite for the development of the country, on the one hand by stimulating economic growth, on the other hand not burdening the social security system and health. (...)" (1). The bill was discussed by the Parliament on 16 July 2015 and voting on its adoption took place on 11 September 2015 – 278 MPs voted in favor, 0 against and 147 abstained. The Senate did not suggest any amendments to the bill and finally it was signed by the President on 26 October 2015.

The objectives of the enactment of LPH were: "(...) the establishment of structures responsible for coordinating and monitoring of the activities of the public authorities that could affect the health status of the population. Another goal is to ensure stable financing mechanisms. (...) The law also aims to systematize the tasks in the field of public health carried out currently, to ensure their continuity, adequacy and comprehensiveness. Public health functions carried out thanks to the adoption of the law will correspond to the objectives in the field of the PH, resulting from the documents of the European Region of WHO (...)" (1).

In accordance with the provisions of the newly enacted LPH (2), funding for the tasks in the field of public health (PH) will originate from the funds being at the disposal of ministers, including the minister responsible for health, the state organizational units and the executive agencies, including the National Health Fund (NFZ), as well as local government units (LGUs). The limit of the budgetary expenditures, resulting from implementation of the provisions laid down by the law, is expected to be PLN 80.7 million per year (including PLN 0.7 million in the budgets of provincial governors) in the years 2017-2025. The executors of the PH tasks determined in the Act may apply also for their financing from the Gambling Problem Elimination Fund, Physical Culture Development Fund and the Sports Activities Fund for the students, while the limit of expenditures from these sources has been set at PLN 60 million per year between 2017-2025 (art. 29 of LPH).

LGUs, as implementers of statutory tasks in the field of the PH, may apply for additional funding from the National Health Fund. They must at the same time demonstrate compliance of the undertaken activities with the operational objectives of the National Health Program and the priorities of the regional health policy. It is also required to obtain a positive opinion of the Agency for Health Technology Assessment and Tariff System. When the formal requirements are met, decisions on financing of the activities of the local government units are taken by the appropriate provincial branch of the National Health Fund. Grants may amount to 80% or 40% of the total planned expenditures. The amount of the funding has been made dependent on the size of the population of a municipality, county or province – higher subsidies will go to the local government, which is inhabited by no more than 5,000 people. The Act has also reserved that additional funding from the National Health Fund can only be received by the units that provide other health care services than those ones specified in the lists of guaranteed services within the realized program. The legislator has also defined the maximum limit of expenditures of NFZ on this purpose – they cannot be higher than 0.5% of the planned value of health care services (art. 22 of LPH).

In the context of the solutions introduced in the Polish system, aimed at providing funds for realization of the PH tasks, it is worth looking more closely at the level of funding for these activities in the European Union (EU).

AIM

The aim of this article was a comparative analysis of expenditures of selected EU Member States and Norway on health care and on the duties of public health.

MATERIAL AND METHODS

The comparative analysis included the expenditures of 22 countries – most of the EU countries and Norway.The data published in the database OECD statistics, based on the System of Health Accounts for the years 2000-2014, was used for this purpose (3). Due to the lack of data or its incompleteness, 7 EU Member States were excluded from the analysis: Bulgaria, Croatia, Cyprus, Ireland, Malta, Romania and the United Kingdom.

The system of Health Accounts (SHA) has been proposed by the OECD (Organization for Economic Cooperation and Development). It consists of a set of basic tables, taking into account: the source of funds in the system, the entities to which the funds are transferred and the services and goods that the money is spent on.

The system classifying the expenditures on health has been described in the new International Classification for Health Accounts (ICHA) by:

1. Classification of Sources of Funding – ICHA-HF.
2. Classification of Health Care Providers – ICHA-HP.
3. Classification of Health Care Functions – ICHA-HC (4).

The functional classification (ICHA-HC) includes: goods and services consumed by the individual people who receive benefits according to individual needs and desires, and the goods and services consumed collectively, provided to the entire population. The specific categories included in the functional classification are shown in table 1 (5).

ICHA classification also includes expenditures on the PH and prevention (code HC.6 – in table 1 marked in grey*), which include: maternal and child health,

Tab. 1. Functional classification of health care

ICHA Code	Health care functions	ICHA Code	Health care functions
HC.1-HC.5	Goods and services consumed individually	HC.6-HC.7	Goods and services consumed collectively
HC.1	Therapeutic services	HC.6	Prevention and public health*
HC.1.1	Hospital treatment	HC.6.1	Maternal and child health, family planning and family counseling*
HC.1.2	"One day" treatment	HC.6.2	Medical school*
HC.1.3	Outpatient treatment	HC.6.3	Prevention of infectious diseases*
HC.1.3.1	Treatment in primary care	HC.6.4	Prevention of non-communicable diseases*
HC.1.3.2	Dental treatment	HC.6.5	Occupational medicine*
HC.1.3.3	Specialist treatment	HC.6.9	Other services in the field of public health*
HC.1.3.9	The remaining patient care	HC.7	Administration health and insurance
HC.1.4	Treatment services in the patient's home	HC.7.1	Government administration
HC.2	Rehabilitation services	HC.7.1.1	Government administration with the exception of health insurance
HC.2.1	Patient rehabilitation	HC.7.1.2	Administration of (public) health insurance funds
HC.2.2	Rehabilitation day	HC.7.2	Administration and health insurance in the private sector
HC.2.3	Ambulatory rehabilitation	HC.7.2.1	Administration and private social insurance
HC.2.4	Rehabilitation in the patient's home	HC.7.2.2	Administration and other private health insurance
HC.3	Services in long-term nursing care	HC.R	Functions related to health
HC.3.1	Stationary long-term care nursing	HC.R.1	Accumulation of capital in the sector of medical providers
HC.3.2	Stationary daily long-term care nursing	HC.R.2	Education and training of medical personnel
HC.3.3	Long-term nursing care provided in the patient's home	HC.R.3	Research and development in health care
HC.4	Auxiliary health care services	HC.R.4	Control of food, hygiene and drinking water
HC.4.1	Laboratory tests	HC.R.5	Environmental health
HC.4.2	Image diagnosis	HC.R.6	Administration and provision of social services for the chronically ill and disabled
HC.4.3	Transport services and emergency assistance	HC.R.7	Administration and provision of cash benefits
HC.4.9	Other ancillary services		
HC.5	Medical products for outpatients		
HC.5.1	Temporary use medicines and materials		
HC.5.1.1	Prescription drugs		
HC.5.1.2	Drugs without prescription		
HC.5.1.3	Other temporary use medical materials		
HC.5.2	Therapeutic equipment and durables		
HC.5.2.1	Glasses and other optical products		
HC.5.2.2	Orthopedic aids		
HC.5.2.3	Hearing aids		
HC.5.2.4	Technical medical devices		
HC.5.2.9	Other medical durables		

Source: J. Suchecka (ed.) 2011 (5)
*Features from the area of the PH (code HC.6) have been marked in grey

family planning and family counseling; medicine school; prevention of infectious diseases; prevention of non-communicable diseases; occupational medicine and other services in the field of public health.

RESULTS

Expenditures on health care in relation to GDP

Globally, expenditures on health care are growing at a very fast pace. According to available data of the OECD, in 2014 the biggest amount was spent health care in Germany and the Netherlands – 11.1% of GDP (tab. 2). It is worth noting that in 2000 the expenditures did not exceed 10% of GDP in any of the examined countries (the greatest amount was spent in Germany – 9.8% of GDP). However, in 2013, for which the data is more complete, more than 10% of GDP was spent on health care in 7 countries: Austria, Belgium, Denmark, France, Germany, the Netherlands and Swe-

den. In the period from 2000 to 2013, the expenditures increased on average by 1.7 p.p. of GDP, which shows the scale of increase in the resources devoted to health care in recent years. In Poland, 6.4% of GDP was spent on health care in 2013, which puts our country on the fourth place from the end – Poland is ahead of only the Baltic countries.

Expenditures on the public health tasks in relation to GDP and the total health care expenditure

The expenditures on the PH were stable in the analyzed countries and in the analyzed period did not exceed 0.5% of GDP (such an amount has been spent on the PH since 2010 only in Finland). Half of the countries allocated to PH in 2013 no more than 0.2% of GDP – the least in Latvia, Lithuania and Greece (tab. 3). Expenditures on the PH tasks accounted for from 0.7% of the total expenditures on health care in Latvia to 5.9% in Finland in 2013 – the average was 2.7% of total expenditure on health (tab. 4). Countries allocating the biggest means to health care – the Netherlands, Sweden and Germany (at least 11% of GDP) – were spending approx. 3% of this amount (fig. 1) on PH. In Poland, 0.2% of GDP was allocated to PH in 2013, which accounted for 2.6% of the total expenditures on health care.

Tab. 2. Expenditures on health as % of GDP

Country\ year	2000	2005	2010	2011	2012	2013	2014
Austria	9.2	9.6	10.1	9.9	10.1	10.1	–
Belgium	8	9	9.9	10.1	10.2	10.2	–
Czech Republic	5.7	6.4	6.9	7	7.1	7.1	–
Denmark	8.1	9.1	10.4	10.2	10.4	10.4	–
Estonia	5.2	5	6.1	5.7	5.8	6	–
Finland	6.7	7.7	8.2	8.2	8.5	8.6	8.7
France	9.5	10.2	10.8	10.7	10.8	10.9	–
Germany	9.8	10.3	11	10.7	10.8	11	11.1
Greece	7.2	9	9.2	9.7	9.1	9.2	–
Hungary	6.8	8.1	7.7	7.6	7.5	7.4	–
Italy	7.6	8.4	8.9	8.8	8.8	8.8	8.9
Luxembourg	5.9	7.2	7.2	6.8	6.6	–	–
Netherlands	7	9.5	10.4	10.5	11	11.1	11.1
Norway	7.7	8.3	8.9	8.8	8.8	8.9	9.2
Poland	5.3	5.8	6.5	6.3	6.3	6.4	–
Portugal	8.3	9.4	9.8	9.5	9.3	9.1	9.1
Slovakia	5.3	6.6	7.8	7.5	7.7	7.6	–
Slovenia	8.1	8	8.6	8.5	8.7	8.7	8.6
Spain	6.8	7.7	9	9.1	9	8.8	–
Sweden	7.4	8.3	8.5	10.6	10.8	11	–
Latvia	–	5.9	6.1	5.6	5.4	5.3	–
Lithuania	–	5.6	6.8	6.5	6.3	6.1	–

Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)

Tab. 3. Expenditures on public health as % of GDP

Country\year	2000	2005	2010	2011	2012	2013
Austria	0.1	0.2	0.2	0.2	0.2	0.2
Belgium	–	0.2	0.3	0.3	0.3	0.3
Czech Republic	0.1	0.1	0.2	0.2	0.1	0.2
Denmark	0.3	0.2	0.2	0.2	0.2	0.3
Estonia	0.1	0.1	0.2	0.2	0.2	0.2
Finland	0.3	0.4	0.5	0.5	0.5	0.5
France	0.2	0.2	0.2	0.2	0.2	0.2
Germany	0.3	0.3	0.4	0.3	0.3	0.3
Greece	–	–	0.1	0.1	0.1	0.1
Hungary	0.3	0.4	0.3	0.3	0.2	0.2
Italy	0.2	0.2	0.3	0.2	0.2	0.3
Luxembourg	0.1	0.2	0.1	0.1	0.1	–
Netherlands	0.4	0.4	0.4	0.4	0.4	0.4
Norway	–	0.2	0.2	0.2	0.2	0.3
Poland	–	0.1	0.1	0.1	0.1	0.2
Portugal	0.2	0.2	0.1	0.1	0.2	0.2
Slovakia	0	0.2	0.4	0.2	0.3	0.2
Slovenia	–	0.3	0.3	0.3	0.3	0.3
Spain	0.1	0.2	0.2	0.2	0.2	0.2
Sweden	–	0.3	0.3	0.3	0.3	0.3
Latvia	–	0	0.2	0.2	0.2	0
Lithuania	–	0.1	0.1	0.1	0.1	0.1

Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)

Tab. 4. Expenditures on public health as % of total expenditures on health care

Country\year	2000	2005	2010	2011	2012	2013
Austria	1.5	2	1.8	1.8	1.8	1.9
Belgium	–	2.7	2.6	2.6	2.7	3.2
Czech Republic	1.6	1.7	2.5	2.3	2.1	2.3
Denmark	3.1	2.2	2.3	2.3	2.2	2.5
Estonia	1.8	2.3	2.7	2.8	3.4	2.9
Finland	4.9	5.3	5.6	5.6	5.7	5.9
France	2.2	2.2	2.1	2	2.1	2
Germany	3.2	3.3	3.4	3.2	3.2	3.1
Greece	–	–	1.4	1.3	1.2	1.1
Hungary	5	4.5	3.8	3.3	2.8	2.7
Italy	2.6	2.6	2.9	2.8	2.8	2.9
Luxembourg	1.1	2.3	1.9	2	1.9	–
Netherlands	5.4	3.9	4	3.7	3.3	3.2
Norway	–	2	2.6	2.7	2.8	2.8
Poland	–	2.4	2.1	2.1	2	2.6
Portugal	2	1.7	1.5	1.5	1.9	1.7
Slovakia	0	2.4	5.7	2.8	4.2	2.1
Slovenia	–	3.7	3.7	3.9	3.8	3.8
Spain	1.2	2.5	2.3	2.2	2.1	2.1
Sweden	–	3.2	3.5	2.9	3	3.1
Latvia	–	0.3	2.9	3.3	2.9	0.7
Lithuania	–	2	0.9	1.3	1.1	1.4

Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)

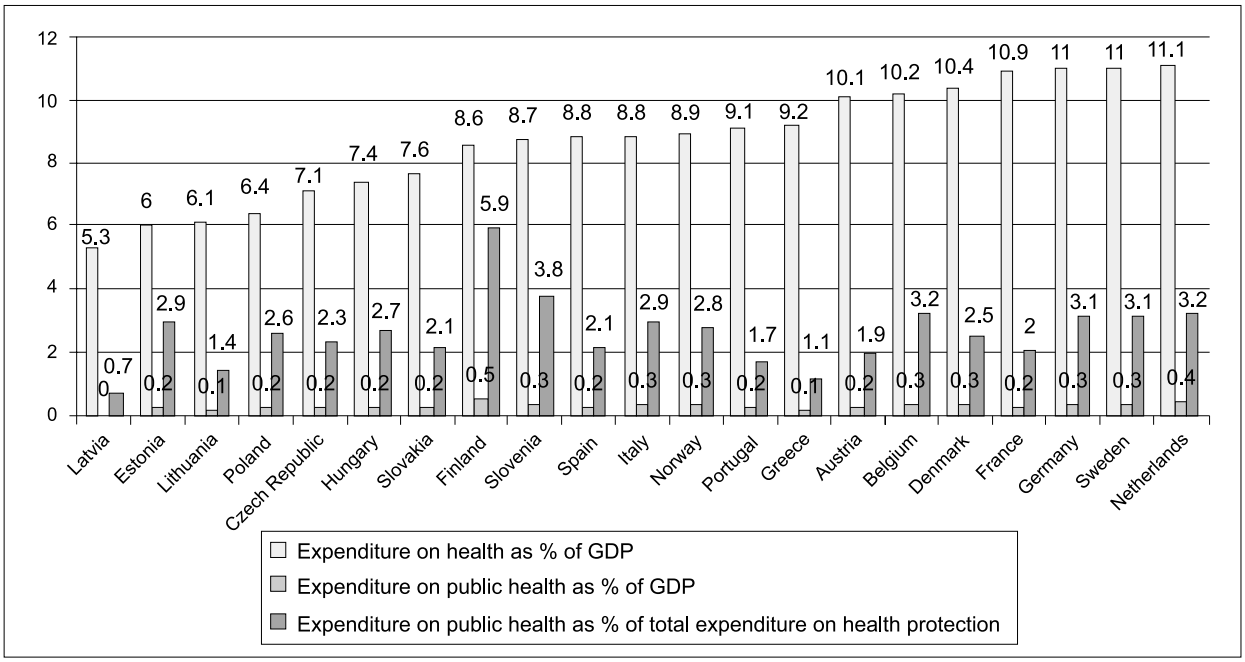

Fig. 1. Expenditures on health care and public health in selected countries of the European Union in 2013
Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)

Nominal expenditures on tasks related to public health

Nominally, the most is spent on tasks in the field of PH in Germany – in 2013 Germany designated for this purpose more than $ 12 billion, almost twice more than in 2000 (tab. 5). France and Italy were next – in 2013, these countries allocated to PH respectively $ 5.5 billion and $ 5.3 billion, i.e. over two times less than Germany. The fact that Poland allocated the same amount to PH as Sweden and Belgium – approx. $ 1.5 billion in 2013 – may be surprising. The least of funds was spent on PH by the Baltic countries: Lithuania – 63 million USD, Estonia $ 59 million and Latvia – 18 million USD in 2013.

The level of expenditures on PH in the Nordic countries (Norway, Sweden, Denmark), where health systems as well as health results and disease rates are considered as ones of the best in Europe, may seem surprisingly low.

In 2013 in the analyzed countries, the average expenditures increased compared to 2000 by 47% and amounted to over $ 1.8 billion on average. The biggest, as much as 230-fold increase in expenditures on PH in the period, was recorded in Slovakia, which raises the question about the reliability of the data.

The second largest increase in funding of the PH was observed in Estonia – in 2013, this country allocated for this purpose about 354% more money than in 2000. The smallest increase in the quantity of the funds was shown by Hungary, where in 2013 11% more of funds was spent in relation to 2000. It should be noted that between 2000 and 2005 the increase was 49% and expenditures on the PH were more or less constant until 2010, when the Hungarians began to spend on public health fewer and fewer funds (in 2013 26% less than in 2010). The data relating to expenditures in Poland are available since 2002, when USD 927 million was spent on the PH. In 11 years, more than 60% of increase of financing on PH was reported.

Tab. 5. Nominal expenditures on public health in selected EU countries in the period from 2000 to 2013 (in million USD PPP*)

Country\ year	2000	2005	2010	2011	2012	2013
Austria	339	543	648	660	684	719
Belgium	–	847	1119	1203	1253	1507
Czech Republic	155	252	486	481	437	498
Denmark	399	374	559	558	567	641
Estonia	13	26	47	50	64	59
Finland	447	686	950	1007	1056	1099
France	3363	4244	5171	5334	5443	5515
Germany	6799	8921	12 004	11 905	12 081	12 180
Greece	–	–	423	387	297	293
Hungary	423	631	631	569	466	468
Italy	2 958	3756	5266	5193	5185	5327
Luxembourg	15	52	60	64	62	–
Netherlands	1902	2259	3083	2976	2829	2742
Norway	–	381	660	731	817	841
Poland	927**	746	1092	1142	1110	1496
Portugal	299	376	414	400	503	452
Slovakia	1	140	586	283	447	231
Slovenia	–	140	179	195	196	195
Spain	710	2306	3165	3025	2887	2788
Sweden	–	822	1146	1278	1339	1465
Latvia	–	5	65	76	67	18
Lithuania	–	55	40	56	52	63

Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)
*PPP – purchasing power parity, **data for 2002

Public expenditures accounted for 80% of the total expenditure for the PH in 2013 on average and were lower by 1.5 p.p. than in 2005 (tab. 6). The PH was financed entirely from public funds in Italy, Belgium and Latvia, while in more than 98% in Greece, Spain and Lithuania. The smallest share of public money was reported in Portugal (38%), Slovakia (52%) and Finland (55%) (fig. 2). In Poland, the rate was approx. 73% in 2013 and was lower by 22 p.p. than in 2002.

Nominal expenditures on public health in relation to the number of population

In terms of per capita expenditures, the most was spent on the PH by the Norwegians – in 2013, it was almost 166 USD per year (128% more than in 2002). The next come the Dutch and the Swedes, spending respectively $ 163 and $ 153 per capita annually (tab. 7, fig. 3). The other extreme is constituted by Latvia (USD 9), Lithuania (USD 21) and Greece (USD 27). In Poland, the amount of USD 39 per capita was designated for the PH tasks in 2013 – more than in 2002 by USD 15 but four times less than in Norway.

The average expenditures on public health per capita in 2013 increased by 119% in relation to 2000 (due to the aforementioned dubious reliability of the data, Slovakia has been omitted in the calculations). The largest increase was recorded in Spain (240%) and the Czech Republic (by 213%) while the lowest – in Hungary (14%) and in the Netherlands (36%). In Poland, expenditures per capita increased in 2013 by 62% in comparison to 2002.

DISCUSSION

For many years reporting on health expenditures conducted by individual EU Member States caused

Tab. 6. Nominal public expenditures on public health in selected EU countries (in million USD PPP*)

Country\ year	2000	2005	2010	2011	2012	2013
Austria	286	443	533	542	556	580
Belgium	–	846	1119	1203	1253	1507
Czech Republic	155	210	422	413	372	424
Denmark	392	364	542	539	546	622
Estonia	13	20	40	40	61	54
Finland	269	419	559	571	595	609
France	2286	2897	3492	3594	3735	3780
Germany	5702	7585	10 368	10 122	10 239	10 272
Greece	–	–	415	382	291	288
Hungary	211	412	415	344	269	267
Italy	2 958	3756	5266	5193	5185	5327
Luxembourg	15	51	58	62	61	–
Netherlands	888	1170	2064	2034	1969	1938
Norway	–	327	591	618	674	694
Poland	877**	548	786	772	769	1089
Portugal	213	281	280	271	199	176
Slovakia	1	78	217	116	119	121
Slovenia	–	105	134	143	143	135
Spain	710	2192	3111	2977	2839	2740
Sweden	–	656	938	1053	1106	1225
Latvia	–	4	64	74	67	18
Lithuania	–	55	38	54	52	62

Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)
*PPP – purchasing power parity, **data for 2002

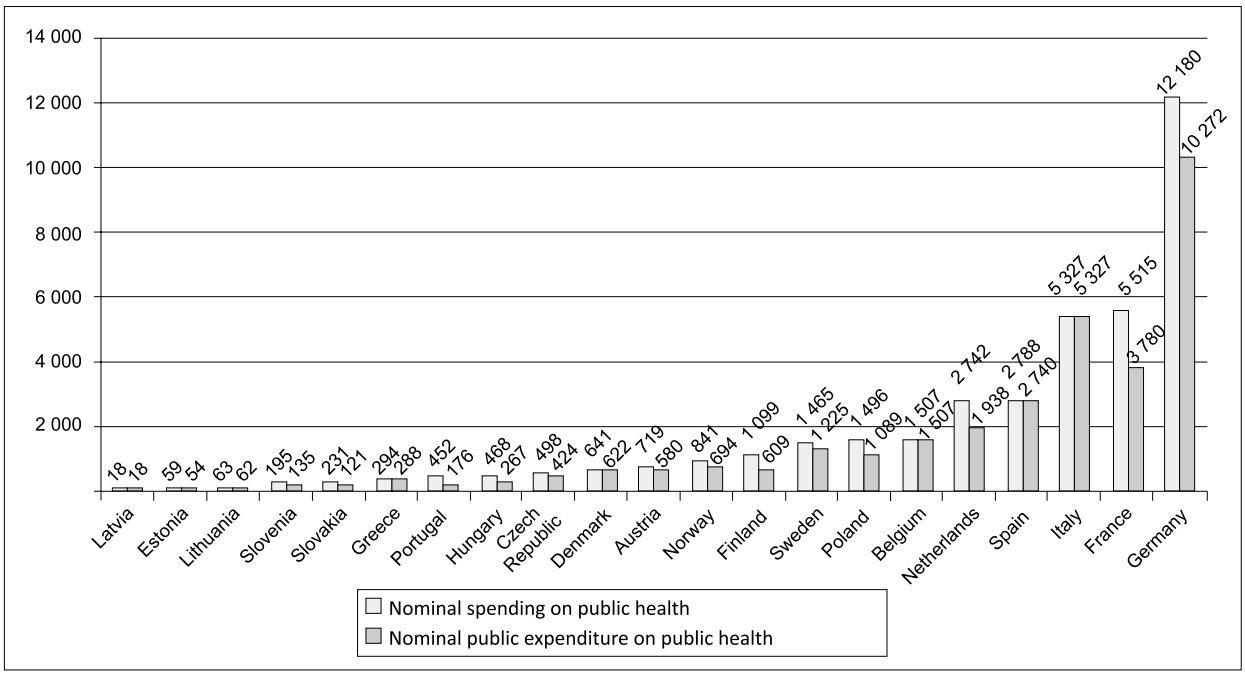

Fig. 2. Nominal total expenditures on public health and nominal public expenditures on public health in selected EU countries in 2013 (in million USD PPP)
Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)

Tab. 7. Total expenditures on public health per capita in selected EU countries in the period 2000-2013 (USD PPP)

Country\ year	2000	2005	2010	2011	2012	2013
Austria	42.3	65.9	77.4	78.7	81.2	84.8
Belgium	–	80.8	102.7	108.9	112.6	134.8
Czech Republic	15.1	24.7	46.4	45.8	41.6	47.4
Denmark	74.7	68.9	100.8	100.2	101.3	114.1
Estonia	9.1	19	35.3	37.4	48.7	44.5
Finland	86.3	130.8	177	186.9	195.1	202
France	55.3	67.4	79.8	81.9	83.2	83.9
Germany	82.7	108.2	146.8	145.5	150.2	151
Greece	–	–	37.9	34.8	26.9	26.8
Hungary	41.4	62.6	63.1	57.1	47	47.3
Italy	52	64.8	88.8	87.4	87.1	88.4
Luxembourg	28.7	85.5	85.3	88.3	83.5	–
Netherlands	119.4	138.4	185.6	178.3	168.8	163.1
Norway	–	82.3	134.9	147.5	162.8	165.6
Poland	–	19.5	28.7	30	29.2	39.3
Portugal	29.1	35.7	39.1	37.9	47.9	43.2
Slovakia	0.2	26	108.6	52.4	82.6	42.6
Slovenia	–	69.9	87.1	95	95.2	94.7
Spain	17.6	52.8	67.9	64.7	61.7	59.8
Sweden	–	91.1	122.2	135.2	140.6	152.6
Latvia	–	2.2	31	36.8	33	8.8
Lithuania	–	16.6	12.9	18.4	17.4	21.3

Source: own study based on OECD data, www.stats.oecd.org (accessed on 15.12.2015)

many difficulties to the analysts. Reliable international comparisons were difficult due to methodological differences in terminology and in the national statistics. The differences in the methods of collecting and analyzing of facts and figures led to the fact that data from individual countries was not comparable. In order to enable the analysis and comparison of countries in terms of size but also in terms of the structure of expenditures on health care, international organizations have decided to recommend the change in the approach to keeping of the statistics on the health-related costs. It was also dictated by the rapid increase in the operating costs of health systems, observed worldwide. The international comparative analyses of rising health care costs are to lead to the development of transnational tools for more efficient spending of available funds and to allow for making of rationalized decisions in the field of health policy. Thanks to the introduction of the SHA methodology by the Central Statistical Office, it is possible to compare the Polish expenditures on health care with the expenditures in other EU countries. An additional benefit from the introduction of Systems of Health Accounts is the ability to make comparative analyzes of expenditures on tasks related to public health.

In Poland, 6.4% of GDP was allocated to health care in 2013, which puts our country on 18th place. The Czech Republic, Hungary and Greece mired in crisis spent more on the health care. On the other hand, the selected European countries allocated in 2013 no more than 0.5% of GDP on the PH, which was from 0.7% (Latvia) to 5.9% (Finland) of the total expenditures on the health. Poland allocated in 2013 0.2% of GDP on the PH, which accounted for 2.6% of the total expenditures on

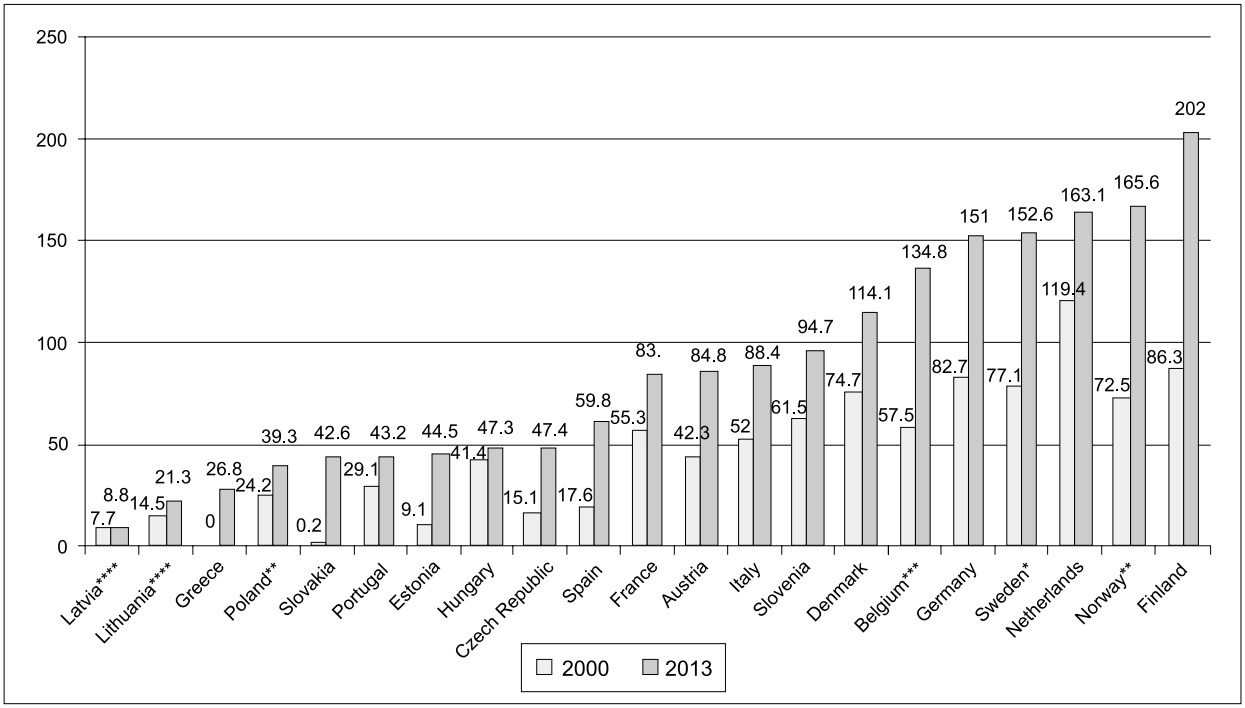

Fig. 3. Total expenditures on public health per capita in selected EU countries in 2000 and 2013 (in USD PPP)
*figures for 2001, **figures for 2002, ***data for 2003, ****data for 2004

health care. Nominally, the most is spent on the actions in the field of the PH in Germany – in 2013, it was more than $ 12 billion. On the other hand, the least is spent on the PH by the Baltic countries: Lithuania $ 63 million, Estonia – 59 million USD and Latvia – $ 18 million in 2013. In Poland, nearly $ 1.5 billion was designated for this purpose in 2013.

These comparisons seem to be particularly important in the context of the newly adopted LPH and the new mechanisms for funding of the PH in Poland, introduced by it. The legislator has secured the amount of PLN 140.7 million per year for realization of tasks in the field of PH. In addition, the National Health Fund may start making additional payments to local governments for the implementation of the health policy programs in the amount of not more than 0.5% of the planned value of health services – in 2016, is the amount of PLN 347.5 million. Funds for the realization of the PH tasks may also come from the resources being at the disposal of ministers, state agencies and executive agencies as well as local government units. The biggest problem of the new legislation seems to be the identification of an excessive number of entities responsible for financing in the area PH and resignation from the creation of the special fund, which the funds for their realization would come from. The capabilities of local government units in the field of financing of their PH tasks have also been overestimated. In 2013, the LGUs allocated for health care in total PLN 3.5 billion (6), of which more than PLN 660 million was designated for the prevention of alcoholism, more than PLN 40 million for to fighting with drug abuse and more than PLN 60 million for health policy programs (7).

Attention should also be paid to the amount of private expenditures on the PH in selected countries. According to the ICHA-HF classification, private expenditures include inter alia direct expenditures of households private insurance sector (including the so-called. quasi-insurance) and the activities of non-profit organizations (5). Therefore, an in-depth analysis of the structure of expenditures on the PH should be performed in order to find out whether the low share of public expenditures in such countries as Portugal, Slovakia and Finland is associated with strongly developed sector of non-profit organizations or rather with heavy encumbrance with expenditures on the PH (vaccinations, preventive examinations) of households.

CONCLUSIONS

The data presented by the OECD show that, as in the case of health care financing, the level of expenditures on the PH is very diverse in the countries of the European Union. However, in all of the analyzed countries, there has been a steady nominal increase of funding these activities over a decade (2003-2013), the amount of money spent on the PH increased by 71% and amounted in 2013 of $ 1.8 billion on average. It shows the growing importance of the PH in Europe.

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