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**„Government regulatory actions in health care
sector with special focus on USA.“**

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List of abbreviations

ACA	Affordable Care Act
CON	Certificate-of-need
DRG	Diagnostic-related groups
DSH	Disproportionate share hospital
FMAP	Federal Medical Assistance Percentage
FFS	Fee-for-Service
HHA	Home Health Agency
HMO	Health Maintenance Organization
HI	Hospital Insurance
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NCQA	National Committee for Quality Assurance
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facilities
PPS	Prospective Payment System
RR	Rate regulation
UR	Utilization review

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1. Introduction

Being healthy is everyone's greatest wish. OECD conducted surveys which outcome pointed health ranked on the top of the most valued aspects for human beings. It is difficult to measure the health status due to a variety of aspects that needs to be taken into account. Generally, in the majority of OECD countries, the health indicators point to very good status of well-being. Nevertheless, there is a large percentage of people that has serious health issues (OECD,2011:3). In accordance with the World Health Report (2008:1), this disproportion has not decreased. Train Kenneth E (1991:1) emphasizes that the reason why regulation is so important is social welfare. However, the pursuit of the highest profit of the firm may decline it and can become an issue for monopolist. This social welfare and individuals well being in context of health depends also on government initiatives and policies along with regulations that provide stability and financial control over the system.

The first part of this paper deals with social insurance policies as well as roots of social insurance. The situation in the health care market in USA is reviewed along with presentation of Medicare and Medicaid programs. The paper continues with the reform of the health system and critical approach as of the current one. In the further sections, the reader will find information regarding the interventions and the regulations of the government, specifically in the health sector. In this part, principal regulatory mechanisms will be brought to further analysis. The reader will get to know why a regulation is important, what the historical outline of regulation in USA is and what a prospective payment system is.

The last section of the paper provides a conclusion. The reader will have an opportunity to gather information concerning the importance of regulation mechanisms in health care sector.

2. Health Care Social Insurance

Markets play significant role in supplying health care. There are economical policies which deal with the efficiency of the health care. In this part of the paper, the main focus will be put on the health insurance policies in USA. The reader will find information about the history of the social insurance system, its criticism as well as the effects of the current implementations.

2.1. History of health care social insurance in USA

Folland, et al. (2007: 461-462) state that at present social insurance programs could be categorized into five groups: poverty, old age, disability, health and unemployment.

Generally, regarding health, people should have a guarantee of well-being and the government should provide health care facilities for everyone. It was in 1883 that Bismarck introduced the social insurance, which was targeted to workers who were sick. (Verspohl, 2012: 17)

Concerning USA health care of individuals, the government usually supports partly or completely poor and elderly people. Unfortunately, there is a number of experts who describe USA as one of the only few developed countries without proper health social insurance programs.

Folland et al. (2007: 463-464) emphasize that the dawn of national health insurance is dated back in 1883 in Germany. Afterwards, it appeared in Europe. European systems, along with the German one, were the proceedings of voluntary organizations. USA has implemented governmental health insurance relatively late in comparison with Europe. The dawn of first arrangement is dated back to 19/20th century. Similarly to Europe, USA began with voluntary organizations that operated

on mutual benefit basis. At the dawn of 20th century, the American Association for Labor Legislation agreed for the health insurance proposals issued by the American Medical Association. The problem was on the political side. Some politicians, like Samuel Gompers, the leader of American Federation of Labor, disagreed with mandatory health insurance policy.

In 1935, the Social Security Program was launched in USA. Folland et al. (2007: 464) state that even though the program received the approval, the opposition was against it and the government health insurance was omitted. Another feature mentioned in the Social Security Act was another conservative aspect of regressive tax, which excluded the coverage for farmers and domestics.

Between the 1940s and the 1950s, the plans for compulsory health care insurance were denied. President Truman proposed such a health insurance system that would not omit the poor, even if lacking of social security. Unfortunately, this proposal remained only on paper.

The debate between mandatory social insurance continued and finally, followed by the presidential election of Lyndon Johnson in 1965, the major programs Medicare and Medicaid were launched. President Johnson has never expected that the programs, primarily targeting the elderly people, would develop in such an extensive way. The debate regarding these two programs started in 1960s. The main concerns were the rising costs. In the 1980s and the 1990s the cost constraint became an important issue. (See also Challenges in the New Prospective Payment System: Action Steps for Social Work in Home Health Care 2005)

In the 1990s, the number of elderly people in the population of USA as well as gradual inflation caused many experts to wonder if the programs did not get out of control. In order to ensure that Medicare has sufficient trust fund to fulfill people's demand, politician were fighting with increased taxes.

Having President Clinton elected, another hope for promising health system reforms appealed. Unfortunately, in 1994, due to the negative opinions of health policy experts and congressmen regarding the efficiency, the plan didn't receive the approval.

2.2. General information about Health Care in USA

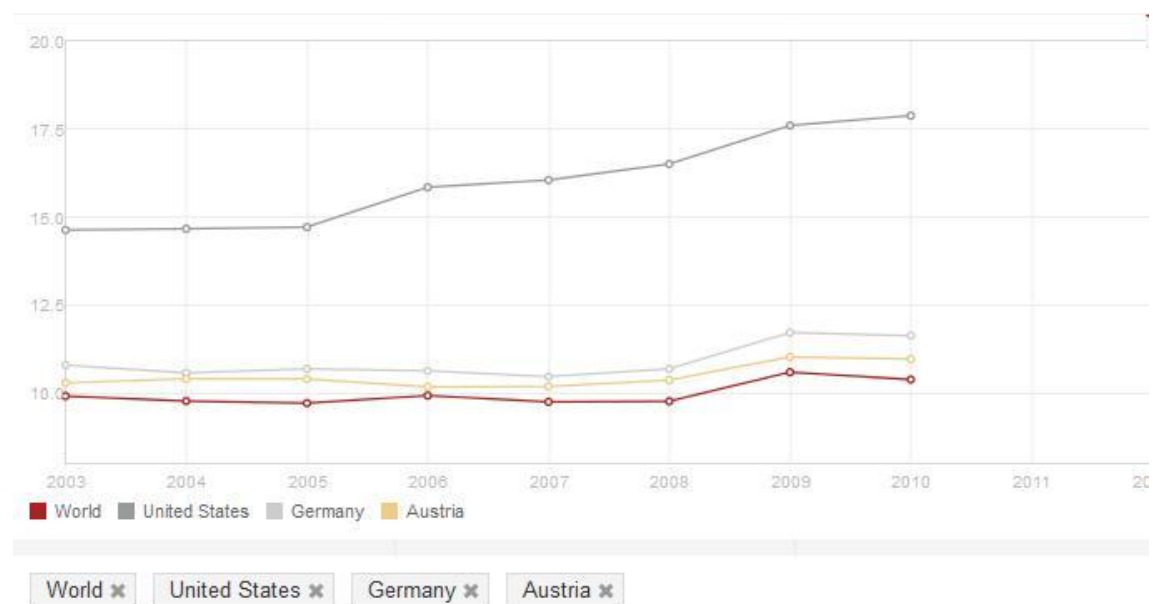
In accordance with WHO and world data bank, the health expenditure as total of percentage of GDP is the largest for USA.

The total health expenditure means “the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.”

(Source: <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-US-DE-AT?display=graph>).

Table 1 presents the health expenditure as total of percentage of GDP in Austria, USA and Germany, and also presents the average expenditure regarding all countries of the world.

Table 1: Health expenditure as total of percentage of GDP

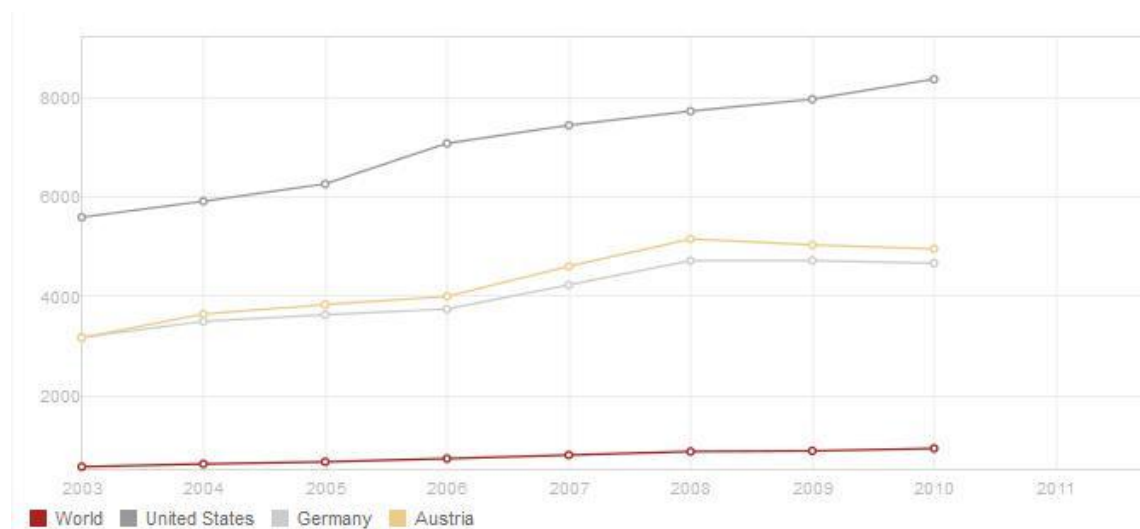


Source: <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-US-DE-AT?display=graph>

Table 2 presents health expenditure per capita. An average American spent in 2010 more than \$ 8.000 for health care from public and private money. Table 2a shows that total expenditure per capita for health was the highest in USA, both private and public.

The gathered data is in dollars.

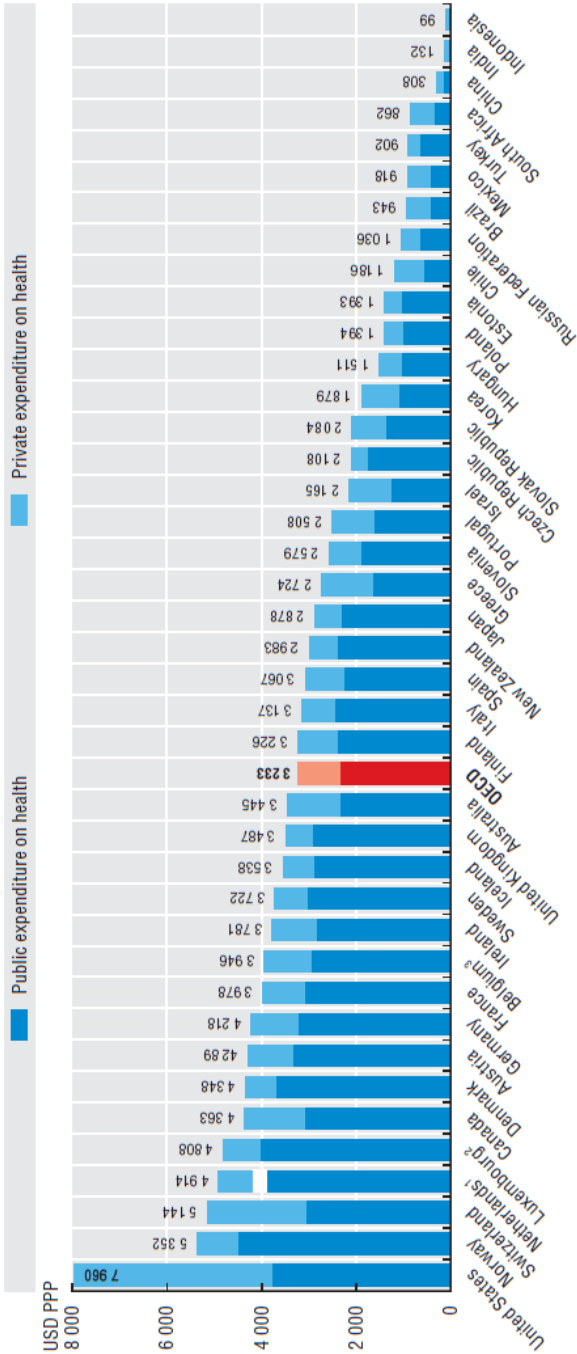
Table 2: Health expenditure per capita (in US \$)



Source: <http://data.worldbank.org/indicator/SH.XPD.PCAP/countries/1W-US-DE-AT?display=graph>

Table 2a: Health spending per capita

Table 2a: Health spending per capita

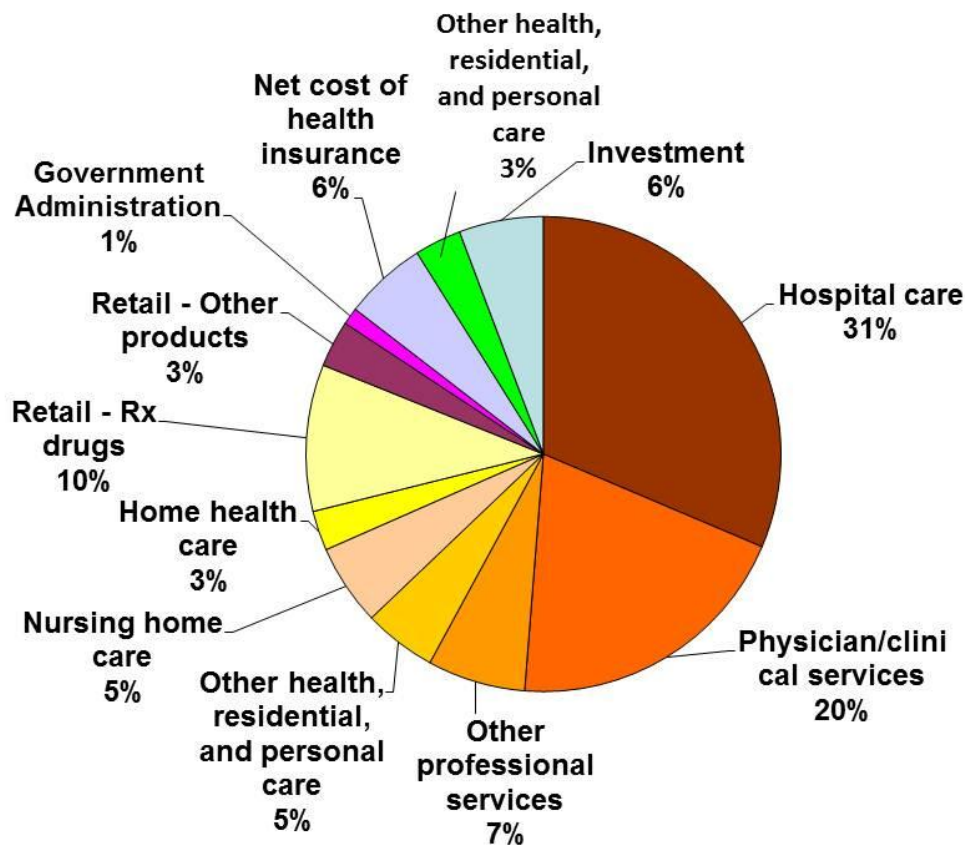


Source: OECD Indicators, Health at the Glance, p.151

Table 3 presents the how public health expenditures are allocated.

There is a global trend in high income countries to shift the healthcare to home-based, day surgeries or outpatient care instead of inpatient service. This is due to high costs, and as the OECD Report mentions (2011:154), this change influences the regulatory issues. Public funds are distributed to Medicare and Medicaid and the prices are subject of constant and tight control. The OECD Report mentions that hospitals should be interested in switching patients to the stationary care due to a lack of control in the prices of interventions. The expenditures of surgeries in ambulatories that were conducted by individual doctors have noted a significant growth between 2003 and 2006 in USA. (See OECD Report, 2011:152)

Table 3: How are expenditures for public health allocated?



Source: Martin A.B. et al., "[Growth In US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009](#)," *Health Affairs*, 2012.

It seems that, compared with USA, there are not many health insurance providers of public programs in EU. USA has been a leader in more privatized system of health care. The Commonwealth Fund states that 56% of people in USA are supplied by a private insurance provider of primary coverage whereas 27% of the citizens are provided with public programs. However, there is 16% of US residents that run out of any health insurance. (see <http://www.aicgs.org/issue/structure-of-the-u-s-health-care-system/>)

The liberal market system of health care exists only in USA as well as in Switzerland. The main role of the state is to provide some security and subventions for the service. (Verspohl: 2012, 36)

There are two main public health insurance programs available, Medicare and Medicaid. They will be reviewed in the next subsection of this paper. They differ from each other at administration and funding level.

A majority of Americans buy a private insurance. There is also a regulation of private insurance companies, but it differs according to each state.

It seems that USA health system is highly decentralized, as well as in majority privatized. Health care providers operate under private ownership without any federal presence. Hospitals and physician's practices are usually also private. However, there are few publically-owned hospitals and general doctors' practices as well. (Compare with <http://www.aicgs.org/issue/structure-of-the-u-s-health-care-system/>)

Table 4 presents the health insurance coverage up to year 2009. The data was collected by Census Bureau which acquires health insurance data by surveys: the Current Population Survey's Annual Social and Economic Supplement, the American Community Survey and the Survey of Income and Program Participation. The first one, the CPS ASEC gathers the data once per year not only nationally but also on state level.

In percentage it indicates that 83,3% of total population of USA had health insurance, whether public or private., but 16,7% had none. Private health insurance belongs to

more than 60% of Americans, whereas a little less than 31% has public insurance. Most of the private based insurance is contributed via employers. Less than 9% of the 63,9% were bought by Americans as direct purchase (not employment based).

Regarding public health insurance, Medicare and Medicaid contribute in almost the same major percentage. 4% of Americans are covered by military health care which is provided by Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs). There is also health care governed by the Health and Medical Program of the Department of Veterans Affairs and care offered by the the military. (See <http://www.census.gov/prod/2010pubs/p60-238.pdf>)

Table 4: Health insurance coverage in USA up to year 2009

Year	Total people	Covered by private and/or government health insurance						Not covered
		Private health insurance			Government health insurance			
		Total	Employ- ment based	Direct purchase	Total	Medicaid	Medicare	Military health care
Number								
2009.....	304,280	253,606	194,545	27,219	93,167	47,758	43,440	12,412
2008.....	301,483	255,143	200,992	26,777	87,411	42,641	43,029	11,560
2007.....	299,106	253,449	201,991	26,673	83,031	39,554	41,375	10,955
2006.....	296,824	249,829	201,690	27,066	80,270	38,281	40,343	10,547
2005 ¹	293,834	249,020	201,167	27,055	80,213	38,104	40,177	11,166
2004 ²	291,166	247,669	200,924	27,551	79,486	37,955	39,703	10,789
2003.....	288,280	244,876	199,871	26,783	76,755	35,647	39,456	9,979
2002.....	285,933	243,914	200,891	26,846	73,624	33,246	38,448	10,063
2001.....	282,082	242,322	201,695	26,309	71,295	31,601	38,043	9,552
2000 ³	279,517	241,091	202,794	26,799	69,037	29,533	37,740	9,099
1999 ⁴	276,804	238,037	200,721	27,731	67,683	28,506	36,923	8,648
1998.....	274,087	233,073	196,536	27,298	66,176	27,890	36,066	8,530
1997.....	271,743	228,800	192,507	26,165	66,087	27,854	35,887	8,747
1996 ⁵	269,094	226,735	189,955	27,431	66,685	28,956	35,590	8,527
1995.....	266,792	225,699	188,224	28,419	69,000	31,451	35,227	8,712
1994.....	264,314	223,733	185,881	30,188	69,776	31,877	34,655	9,375
1993 ⁶	262,105	222,387	184,318	31,349	70,163	31,645	33,901	11,165
1992 ⁷	259,753	220,040	182,351	(NA)	68,554	31,749	33,097	9,560
1991 ⁸			148,318					39,713
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Regarding the excellence of health care, even though there is large amount of money that USA puts on health care, the quality of service does not definitely appear to be proportional to the spending. Life expectancy is lower than the OECD level of average and the amount of physicians is not enough in relation to the amount of people. The same issue involves the duration of the stay in hospitals as well as the amount of hospital beds, which are relatively low in both cases. These factors indicate that the spending on health should not be as high as it is now. (<http://www.oecd.org/unitedstates/49084355.pdf>)

2.3. Medicare and Medicaid in USA

As mentioned above, the major programs Medicare and Medicaid were launched in 1965. Medicare and Medicaid provide mandatory hospital insurance.

Medicare is a national program, which targets elderly people. There is an additional coverage that people can choose to pay or not invest in it. Medicaid is a state-operated program targeting poor people.

2.3.1. Medicare

There are four pillars in Medicare Program: Hospital Insurance (HI, also mentioned as Part A) and Supplementary Medical Insurance (SMI, named also as Part B), the Medical Advantage program (described as Medicare Choice Plus Program, also as Part C) and the last one, a new prescription drug benefit (also known as Part D).

The third pillar as well as the fourth part were modified by the public law by the Balance Budget Act and the Modernization Act of 1997. Part C provides the opportunity to benefit from private sector health care.

The actions of a new prescription drug benefit (Part D) are conducted by Supplementary Medical Insurance trust fund, which has a separate account in

managing SMI. At present, SMI is divided to Part B and D. As Medicare was launched on July 1, 1966, 19 million people were eligible. This amount more than doubled in accordance with the data from 2004. In that year, around 5 Million people have chosen the non-mandatory Medical Advantage program (Part C). (Source: Centers for Medicare and Medicaid Services Data Compendium, 2003-2005).

The coverage for medical treatment in Part A is reserved for people of 65 years old and older as well as disabled people with the diagnosis of at least two years. These people have to be registered in whether Social Security or Railroad Retirement Board benefits. In accordance with Centers for Medicare and Medicaid Services Data Compendium, there were 41.7 millions of beneficiaries in 2004, namely 35.4 Million elderly and 6.3 million disabled people enrolled.

The Hospital Insurance package consists of:

- ⇒ Inpatient Service in hospitals that require primer deductible payment and extra payments after 60 days in the hospital.
- ⇒ Skilled nursing facilities care (SNF)
Skilled nursing facilities care are free for people enrolled only under the following conditions. Firstly, it has to be medically certified that the stay in SNF is necessary. Secondly, the stay has to be not longer than thirty days of hospitalization that lasts a minimum of three days.
In accordance with the homepage of Medicare & Medicaid Services (www.cms.gov), it was announced on 27.09.2012 that there were seven agreements that were signed in order to advance the excellence of health care and to diminish hospitalization costs.
- ⇒ The Home Health Agency Care (HHA).
This service provides the house care help
- ⇒ Hospices
Hospices are designed for people who have predictable life expectancy of less than half of the year due to their sickness.

Regarding Part B, the SMI, the coverage for medical treatment in this part is reserved for residents aged more than 65 years old. In order to be able to obtain the benefits from this optional package, these groups of residents have to contribute to monthly payment.

In Part B, the following services are included:

- ⇒ The services of general practitioners and surgeons, also in non-hospital facilities
- ⇒ Some dental care, optometrists, chiropractors and podiatrists;
- ⇒ Emergency service;
- ⇒ Service in outpatient clinic; and
- ⇒ Clinical laboratory tests, diagnostics.

Part B provides health aid for around 39 million people including 33 million aged 65 and more, and 6 million disabled people.

All in all, mostly people who are enrolled in Part A also choose an optional B.

Permanent residents that are entitled to both first parts can also obtain medical service alternatively provided by Medicare Advantage Program, namely Part C. This service is provided by organizations that meet specific program requirements, including financial issues.

There are some services missing in Medicare. These are: long term nursing care, dental care, hearing aids, etc. Since 2006, for beneficiaries of Part A or B, it is possible to buy an extra service of Part D, in which most FDA-approved medical prescriptions as well as biological are covered.

2.3.1.1. Medicare Financing

The Medicare Program is financed by various means. Part A is financed by FICA tax, which is an obligatory deduction of payroll. FICA's amounts to 1,45 % for employed

people (and is also paid by the company) or 2,90 % for self-employed respectively. In 2013, it will be raised due to Health Care reform signed by president Obama.

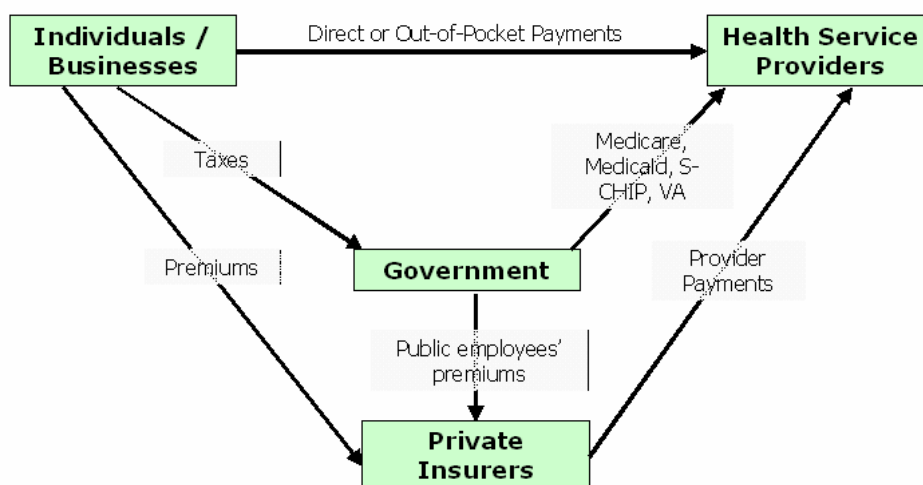
Regarding SMI, there are two separate trust funds for Part B and D. The financing of them comes from “beneficiary premiums as well as contributions from the general fund of U.S. Treasury.” (Folland et al, 2007: 469)

More specifically, the money necessary for the existence of Part B is in major part from general fund of U.S. Treasury because the beneficiary premiums can cover around 25% of expenses for elderly beneficiaries. The situation with Part D is very similar. The percentage is slightly higher, it oscillates at around 25,5%.

The table below presents how the U.S. Health system is financed. As mentioned above, regarding Medicare, it is money coming from taxes that finances Medicare.

In Europe, due to limited information that the patient has regarding medicine, the third-party-payer system was established, which replaced the patient-provider relation. (Verspohl, 2012: 42). Verspohl (2012:43) also mentions that even though US health systems is one of the less efficient in the world, there are some market instruments in the EU that are taken explicitly from USA, namely DRGs as well as disease management system.

Table 5: How is the U.S. Health system financed?



Source: Kao-Ping Chua (2006:4) Overview of the U.S. Health Care System

What about the provider payments?

In the 1960s, the first remuneration model was proposed by researchers from Yale University. This system had its basis on groups of diagnoses with very similar expenditures of treatment. Since the year 1983, it is regulated by Prospective Payment System (PPS) within Medicaid. (Verspohl, 2012:43)

In PPS, the hospitals are refunded in accordance with fixed amount of money depending on diagnostic-related groups (DRG) of their admissions. Patients' sicknesses are clustered accordingly to their similar conditions in groups. There are about 504 groups in PPS. Each group carries "a relative weight that compares its costliness to the average for all DRGs." (Folland et al, 2007:560)

Consequently, the genuine cost of the medical service in hospital might be lower or higher than charged by the classification. This indicated loss or profit for the hospital. There are payment adjustments but only for special cases, for example, rehabilitation, nursing homes, home care or psychiatric service. These medical treatments are made on reasonable cost basis. After the year 1992, outpatient service and home health care operated also on the basis of PPS. No additional fees can be added by doctors or suppliers once the program-rate is approved. Doctors have to sign the acceptance of assignment for all Medicare service for the forthcoming year if they want to be part of the program. The regulation will be mentioned in the next section of this paper. The next table 6 portrays the essence of Medicare.

Table 6: Summary of Medicare

	Medicare is a national program that includes individuals of 65 age and more, and disabled
	Medicare is administered by the government. Government takes care of reimbursement.
	Medicare is financed by income taxes, a FICA payroll tax, beneficiary premiums for B and D.
	Coverage: each part of the program covers certain services.
	However, the coverage is not complete (for skilled nursing facilities, incomplete preventive care coverage, and no coverage for dental, hearing, or vision care.) Lot's of seniors obtain a supplementary insurance that takes around 22% of their disposable income.

2.3.2. Medicaid

Medicaid was established along with the Social Security Act in order to provide the medical help to the poorest. In 2003, health care was provided to approximately 41 million people. The total costs for the program was of \$223 billion.

Medicaid combines all of the four programs in a single one. (Folland et al., 2007: 471). There is a precise list of eligibility criteria of Medicaid's coverage. In general, with some exceptions, the first major group (3/4 of all beneficiaries) that Medicaid is designed for are poor women and families with children. The second one refers to medical treatment of elderly people that Medicare does not cover. The third one is created for poor disabled, and the last one covers the expenses of nursing places for elderly people.

The service and its duration that is covered differ from state to state. However, there are national guidelines that determine eligibility standards and rate of payment for service.

Regarding the payment for the service in Medicaid, it is possible to have Fee-for-Service (FFS) payment for providers or certain prepaid deal with, for example, Health Maintenance Organization (HMO). The decision for payment choice and its calculation, namely the payment rate is left to the province. The state is obliged to make adjustments, called disproportionate share hospital adjustment (DSH), if the amount of Medicare inpatient beneficiaries in qualified hospitals is disproportional.

National authorities, along with state government, are partners in Medicare. This means that they both participate in the costs of the program. Federal government pays its share on the basis of the Federal Medical Assistance Percentage (FMAP), between 50% and 83%. FMAP is calculated accordingly to the comparison of state and country income average. The higher income per-capita, the less the reimbursement.

Generally speaking, there is a relationship between Medicare and Medicaid service. Medicaid service extra coverage is very often provided for Medicare patients. People who have low income and are eligible for Medicare, might receive aid from Medicaid. Medicaid provides, therefore, a supplementary coverage service to Medicare.

2.4. Criticism of the health system in USA

There are major drawbacks in Medicare and Medicaid system. The reform of the health care system in USA addresses some of the problems that are reviewed below. In this section of the paper, these limitations will be briefly outlined.

The first issue that is pointed out by critics of Medicare and Medicaid are uncovered expenditures. In accordance with the data gathered by Folland et al. (2007: 486), in the year 2006, the patients had to cover 238 dollars/day themselves for the stay in the hospital from day 61 to 90. This amount rose up to 456 dollars/day if the stay was from the day 91 until day 150.

Moreover, people entitled to Medicare B program had to pay: 88,50 dollars premium amount/month, 124 dollars annual fee, 20% of the approved covered fee (so called coinsurance payments), around 50% for major outpatient mental health.

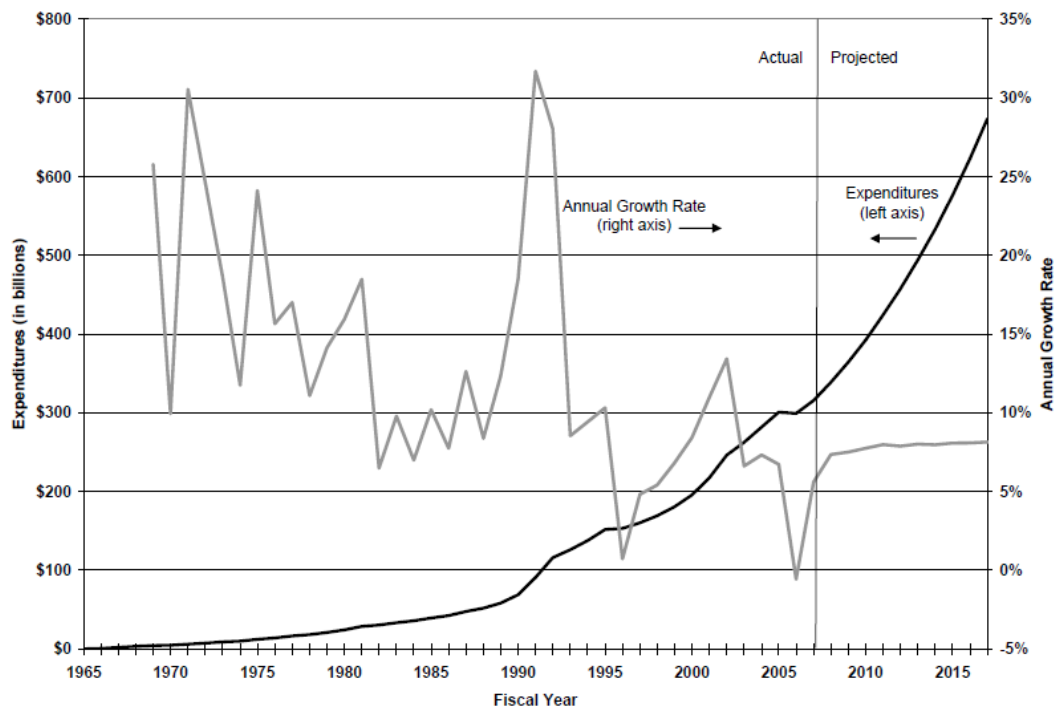
Folland et al. (2007: 486) also mentions that there is plenty of medical service that Medicare does not cover, namely dentist, medications, glasses as well as long-term medical care.

Regarding Medicaid, Folland et al. (2007: 486) refers to the work of Gruber, whose research states that even though 31% of kids were eligible for the program, the percentage of enrolled ones was only 22,6.

Furthermore, critics of USA health system state that one of the main problems in USA is the amount of people without any health insurance. Folland et al. (2007: 487) mentions the surprisingly high amount of 45 million people without any medical coverage. Fortunately, these people still receive the some kind of health care.

The observed trend is an increase in spending as well as the enrollment. This growth in enrollment is justified by recession in economy and what follows it, lower incomes. The table below illustrates the enrollment and spending in Medicaid.

Table 7: Expenditures and Annual Growth rate for Medicaid



Source: Medicaid Report 2008, p. 25 (available online: 29.11.2012 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/medicaidreport2008.pdf>)

2.5. Barack Obama's healthcare reform

23.03.2010 was a historic day for US health system. President Obama has approved the reform that should have been passed years ago, according to critiques.

Why does USA healthcare system need help?

Blumenthal and Dixon (2012:1352) state that USA and England face similar problems with health care. They mention the importance of Affordable Care Act (ACA) and its effects on health care. The important issues that are pointed out by the authors are: more cautious medical expenditures (at around the level of the growth of GDP) and encouraging quality of the service by providers. The reform proposed by Obama addresses these issues.

Firstly, the system was inefficient, inequitable. Almost 18% of GDP of USA which consist of one half of public expenditure budget falls into health care that is unable to provide insurance for 1/6 of population. (see Blumenthal and Dixon, 2012: 1352)

Secondly, it is due to Medicare growth and the shortages in budget (estimated shortage over \$660 Billion in 2023) (also see Journal for Health Care Practice and Risk Management, 2009).

All in all, after the reform, the health care service will be more available and more affordable for citizens. US news wrote that up to the year 2010, the hospitals will have to treat children patients with pre-existing illness. Moreover, there will be many prophylactics plans established, which will include preventive care, for instance, of cancer or diabetes checkups. Furthermore, as it is in Poland, children until the age of 26 will remained co-insured by their parents insurance coverage.

(Compare <http://www.usnews.com/topics/subjects/healthcare-reform> and http://praca.gazetaprawna.pl/artykuly/497136,pracujacy_rodzic_zglasza_uczace_sie_dziecko_do_ubezpieczenia_zdrowotnego.html)

The reform goes even beyond that; dawn 2012, it ensures full coverage for patients with pre-existing medical issue will be a must. Moreover, companies, where more than 50 people are employed, are obliged to purchase health insurance under the threat of financial consequences.

(See <http://www.usnews.com/topics/subjects/healthcare-reform>)

The extension of the health insurance service will be enormous; more than 32 million uninsured will receive a medical coverage.

Beneficiaries of Medicare will receive an extended health care, for example free annual wellness visits. Patients will have to pay less for extra services. Other essential changes are the following:

⇒ “Payments to insurers offering Medicare Advantage services are frozen at 2010 levels. These payments are to be gradually reduced to bring them more in line with traditional Medicare. (...)”

- ⇒ “Physician payment reforms are implemented in Medicare to enhance primary care services and encourage doctors to form "accountable care organizations" to improve quality and efficiency of care. (...)”
- ⇒ “An incentive program is established in Medicare for acute care hospitals to improve quality outcomes. (...)”
- ⇒ “The Centers for Medicare and Medicaid Services, which oversees the government programs, begin tracking hospital readmission rates and puts in place financial incentives to reduce preventable readmissions.”

(source: <http://www.telegraph.co.uk/news/worldnews/barackobama/7495825/US-health-care-reform-bill-the-facts.html>)

In the year 2013, there will be a test program set for Medicare on payment bundling to health system providers in order to ensure a better coordinated patient service. Moreover, the FICA tax will be raised to 2,35 % from current 1,45 % for high income individuals as well as marriages (income more than \$200,000 or \$250,000 respectively).

In the year 2014, it will be mandatory for US citizens to have a medical coverage. In case of none, there will be a severe fine. Moreover, nobody will be rejected from the medical service just because of already being sick.

Furthermore, it will be mandatory for companies who employ more than 50 people to pay for insurance.

The another major change will be directed to health insurance corporations who will be forced to pay a charge on the basis of their market share.

In the year 2015, Medicare will establish a special program for general doctors, called physician payment program, which aim will be to enhance the quality instead of quantity of health service. The program will provide awards for physicians. (see also: Journal for Health Care Practice and Risk Management, 2009)

Blumenthal and Dixon (2012:1352) share their fear of feasibility of the reform due to high federal deficit of USA and the need to keep the costs under control.

Dr. Blumenthal emphasised that that even though the changes in health system were barely possible in 2004, they turned out to really appear.

(See The Quarterly Journal for Health Care Practice and Risk Management V.11 2009, p.8)

Blumenthal and Dixon (2012) state that the health care reforms that were proposed in USA can be put to three different categories: financial, organisational and informational. In this section of the paper, the reader will find out information regarding these three categories.

2.5.1. Finance

Until recently, there was no binding overall budget for the two programs, Medicare and Medicaid, but only the cost estimations. The USA government is forced to pay the expenses of eligible beneficiaries. The authors emphasise that the cost curve has to be changed. There was a need to create very complex algorithms models of expenditure. Regardless to this analysis, the Centres for Medicare and Medicaid Services (CMS) along with the Congressional Budget Office decided to conduct their own independent research and analysis, including external consultations and reviews. These all actions should allow predicting the trends in effects of the changes in programs. (See Blumenthal and Dixon, 2012: 1353).

The developed formula was defined as sustainable regarding the changes in the prospective payment system, medical coverage and inpatient care of Medicare. The ACA is targeted to payment reform in Medicare. The costs of inpatient care, ambulatory, outpatient service, some inpatient services and medicaments will slightly rise. The authors mention the charges of doctors participating in Medicare. They are established in accordance with resource-based relative value system. This system provides a unique, sustainable mathematic formula. In accordance with the authors, a

consequence of its implementation seems to be that the raise of doctors' expenses per covered person will not go beyond the predicted growth in GDP of USA.
(See Blumenthal and Dixon, 2012:1353).

The Prospective Payment system was launched 30 years ago. The prices that cover the inpatient care are updated once a year by CMS and the previous fee-for-service system is now only used by general doctors. The aim of the changes is to integrate the services within the settings. ACA makes it possible for CMS to analyse the new bundled payments, which are different with regards to service (inclusion of inpatient doctor's and post-acute care).

The scholars emphasise the changes that reform will bring, namely, the incentives for hospitals to provide better quality service. The low performance will be subjected to penalties. Starting from the year 2015, the value-based payment system will be introduced and implemented by physicians. Hospitals will have to set efficient controls for readmission for Medicare beneficiaries and hospital-acquired illnesses.
(See Blumenthal and Dixon, 2012: 1354).

The payment reform that will be introduced will raise the awareness of provider costs in the process of making clinical decisions. The scholars point out that a consequence of ACA, Medicare Shared Savings Program, will be created where "providers can create so-called accountable care organisations that can retain part of any savings (and eventually share losses) that they achieve by delivering services to Medicare patients." (Blumenthal and Dixon, 2012:1354). These organisations are focused on primary health service and are commonly and equally responsible for the costs and quality.

2.5.2. Organisational challenges

There are two organisations that were established along with the health care reform: Independent Payment Advisory Board and Centre of Medicare and Medicate Innovation. ACA sets the limits for Medicare expenditures. Those ways to contain

them will be reported to the Congress as well as to the president. Centre of Medicare and Medicate is subject to CMS.

The scholars point out that the aim of this subunit is to create and estimate new models of payment for services that will cut the costs and raise the quality of health care. The budget of the centre is high, namely 10 billion dollars for 10 years. Due to the high budget, these changes are likely to be implemented. It seems that ACA targets wider presence of primary health care and better coordination of serious, long-lasting illnesses. As a basis, the UK's model was taken as an efficient example. (See Blumenthal and Dixon, 2012:1355).

The fees for Medicare and Medicate are expected to rise due to planned enlargement of supply of primary-care doctors and establishment of special medical centres.

2.5.3. Information

The health care quality standards as well as the cost of the health service will be distributed by various informational channels. Information management plays here a significant role in creating better and valuable health care system.

Patient Centred Outcome Research Institute will provide a support in research. It will be financed from both public and private money. The scholars mention that it is essential to establish standards in health informational system. This electronic system should be secure and private. As a consequence, a better flow of local information as well as information regarding serious, chronic illnesses could be exchanged.

(See Blumenthal and Dixon, 2012:1355)

All in all, regarding the reform of health system in USA, the scholars mention that it is essential to deliver an efficient and effective service under the budget restrictions. They mention it as very challenging. The USA change the payment for providers of health care, namely by bundling payments and establishing special financial incentives regarding the quality. The estimated prices in the health market will significantly go down. Moreover, there will be plenty of organisational modifications.

Furthermore, the USA will put more focus on primary care and its availability and are planning to invest much money so that these changes will bring the expected output.

3. Intervention of government in the health care market

As government is the financial, organizational and regulation heart of health care service, the reasons for and the scale of the intervention will be outlined. At first economic reasons for intervention will be described in this section of the paper. The question of government failure as a regulator will be brought into deeper analysis.

3.1. Reasons for the intervention

If the resources were allocated efficiently, there would not be a market failure. This situation is not very common due to various distortions in the market. A situation on the market that is ruled by a monopolist provides a classic example of market failure.

A Monopolist or a company with monopoly power, which maximizes its profit, will wish to obtain such a level of output at which the revenue is equal to marginal cost. The MR is below the demand curve. Therefore, the level of output diminishes and the price is situated higher than the MC of production. A welfare loss appears. In this case the regulatory institution should intervene and by its actions create the highest possible output and the least welfare loss. Some experts argue that if regulation of the market is necessary, but the others don't. By setting a price cap that established the limit of price that monopolist can charge, the welfare loss decreases and the monopoly profits are under control.

The other reason in favor of government intervention could be the stabilization of the economy. The government might also intervene in health care sector by helping spreading the knowledge to people. One form of it is direct provisions. The other

option is subsidizing the private sector actions. The government might also be more active itself and invest money in scientific research.

It should not be overseen that government might also take actions to promote the consumption of merit goods. People might not always know what the best for their health is. Government might lead some public health interventions, such as alcohol abuse or seat belt usage.

3.2. Categories of government interventions with relevance to health care

The policies of the government regarding the better allocation of resources can be various regarding the sector of the intervention. Folland et al. (2007:412) emphasize that there are few categories that intervention falls into: commodity tax and subsidies, public provision of health care, transfer programs and regulation.

Regarding regulation, the government controls the conditions of production and consumption. What can be governed by the authorities? It might be: prices, quantity, quality of health service, mandates, as well as licensure laws. This part of paper concentrates itself on regulations. In the next section of the paper, the regulations will be brought into deeper analysis.

3.3. How is the government involved in health care market?

Most of economic activities are subjected to intervention. Folland et al. (2007:415) mention the activities of involvement: provision of goods and services, redistribution and regulation. These activities are the worry of health economists. There are public hospitals that provide health care. Hopefully with the recent changes in the health reform, the major drawbacks will be efficiently addressed and modified.

Government, more directly, the regulatory agencies, plays a significant role as a regulator in health care. There are various examples of regulatory agencies, Occupational Safety and Health Administration, Securities and Exchange Commission, etc. There are some examples of how the government intervenes in health care markets in the section below.

3.3.1. Hospitals' support

The modern hospitals have appeared after the year 1800. They started serving the medical help for the poor and later on to the middle-income groups in order to struggle with negative impacts of dangerous diseases, like tuberculosis. At present, there are many states as well as federal regulations which aim to control the quality along with the costs and the reimbursement. The licensure is given to hospitals by the state. The quality programs are very often designed by the hospitals themselves. However, in 1971, there was a legislation created to control the quality and utilization in the hospitals. In 1984, the professional standards review organization changed to peer review organization. In 2002, there was another replacement. From this year, it is quality improvement organization that controls and guards the health care.

Regarding the regulation of the hospitals, generally it is Medicare's prospective payment system that deals with the directive of the reimbursements. There are also other forms of regulations. Folland et al. (2007:297) states that certificate-of-need (CON) sets a financial limitation cap on capital spending. Hospitals are subject to antitrust.

There is another issue of accreditation that hospitals aim to get. The accrediting institution is the Joint Commission on the Accreditation of Healthcare Organizations which is a non-profit organism that examines the hospitals under the its standards.

3.3.2. Hill Burton Act

In 1946, the Hill Burton Act was signed. After the World War II, two senator, Hill and Burton, initiated this Act. On the basis of this Act, the government was providing grants for construction of hospitals. This program helped to raise the amount of beds in the hospitals between 1947 and 1970. Later on, when the cost issue was emphasized by governments, there were agencies established that guarded the costs and limited the growth of hospitals. As a consequence, the Certificate of Need was introduced.

3.3.3. Veterans Administration

The government is also a health provider itself. Folland et al. (2007:416) mentions that public hospital beds consist one fifth of total amount of them. The Veterans Administration is the biggest one. Patients that are treated via this provider have service-related injuries.

3.3.4. Tax subsidies

Both federal and state governments guarantee tax subsidies when the consumption of health service is not absent. Moreover, it definitely is the issue when insurance is purchased. Folland et al. (2007:417) state that “in particular, employer contributions to group health plans are not included in an individual’s taxable income (escaping federal, state and social security taxes).”

3.3.5. Other programs

There are plenty of other examples how the government is involved in health care. The government takes part in medical education and supports medical universities. Moreover, the health care research lies also in interest of government. Therefore, the government also provides support in this field, for instance via National Cancer Institutes.

Government actions in health care sector are connected with many economical problems. One of them is a government failure due to lack of information or efficiency, or because of bureaucracy.

Folland et al. (2007:428) emphasizes that government deals with this problem by introducing a heavy regulation. This is the subject that will be deeply analyzed in the next section of this paper.

4. Regulation of health care market.

What is the regulation? Ensor and Weinzierl (2007:355) define it as bureaucratic and administrative controls of government that will lead to prevent market failure.

In this part of the paper, the reader will find information regarding the regulation in the health care market. The objectives of the regulation will be reviewed, the mechanisms specifically related to health care will be discussed along with the historic outline of regulation in USA.

4.1. Objectives of regulation

Why regulating? What is regulation? Utilities are regulated in order to have control over the market power, to facilitate the competition, enhance investment and provide stabilization on the market.

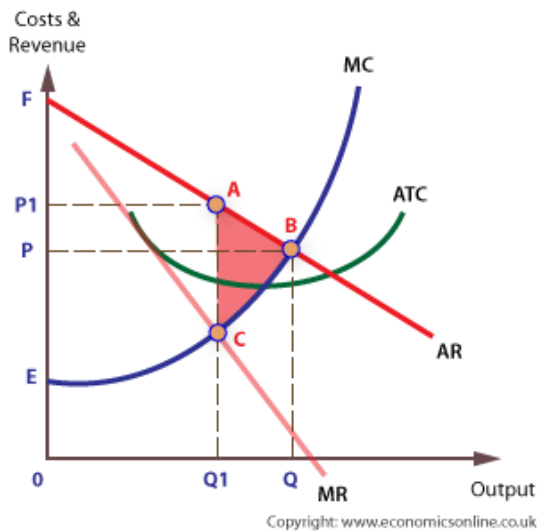
In USA, as in other countries, there are regulatory agencies that control the market, that manage the costs. The performance of the sector, that regulators take care of, might be checked by various measures, for example by net consumer surplus, cost efficiency, the accuracy of prices, the scope of innovation, variety of service, etc. In order to fulfill completely this aim, the regulatory institutions are requested to adapt their strategies and policies that will attract the capital flow to investment, which as a consequence will lead to profit from licenses, more efficient market-based

competition, encouraging the operators to be more efficient and easing the general access. (See <http://www.regulationbodyofknowledge.org/chapter1/narrative/03/>)

Kenneth Train in his book *Optimal Regulation* mentions the importance of regulation in avoiding the welfare loss in the society and creating the desired output of production. Kenneth Train mentions that the first issue is the statement of a desired output. Once it is characterized, the regulatory mechanisms must be identified. Ideally, the company can maximize its profit and the outcome is socially optimal.

The following graph presents the welfare loss under monopoly situation.

Table 8: Welfare loss in monopoly



Source: http://www.economicsonline.co.uk/Business_economics/Monopoly.html

Folland et al (2007:432) emphasize that the regulation targets the quantity of service, rather than quality.

In 1963, Arrow noticed that there are information asymmetries and uncertainties in health care (for example in the relation doctor-patient, the patient cannot verify if the doctor is accurate about the diagnosis). Kenneth Train also mentions the problematic of information asymmetries. Arrow emphasized that only with the help of non-market

intervention the health care sector could be efficient. In health care system, regulation could be introduced to the doctors as well as to the system itself.

Folland et al. (2007:432) mention that regulation of fees as well as hospital revenues and costs was the consequence of market failure. It is regulation that might modify the quality, quantity, or price of service.

4.2. Forms of regulation

Jacobson (2001:1167) underlines that while choosing the type of regulatory system, the following questions must be answered: What issues should be regulated, how the regulatory structure should look like, and last but not least, the question regarding the content of regulation. In USA in the last 30 years, the reasons for regulation were cost reduction, quality enhancement and enlargement of access. (Jacobson 2001:1167).

The form of regulation could be whether on state, federal or both state and federal level.

Jacobson mentions other possible structures: “industry or professional self-regulation (a voluntary market-based approach), a mixed-form of public and private sector initiatives, and market self-correction.” (Jacobson, 2001:1167).

Regarding the content of regulation, there are also many options: general guidance (for example NCQA standards), prescriptive detail (partly subject to penalty), as well as compliance agreements, which feature is flexibility in accomplishing standards.

(See Jacobson, 2001:1167)

The following table presents various strategies of regulation.

Table 9: Regulatory Strategies

Regulatory strategy	Relevance to the health sector	Weaknesses	Regulatory strategy	Relevance to the health sector	Weaknesses
<i>Command and control</i> Backed by criminal sanctions	Standards of behaviour / codes of conduct backed up by penalties	Complex and inflexible rules Enforcement can be difficult and costly Compliance costs high Penalties only function if incentives to remain inside sector are sufficient Regulator must be seen to be independent	Specific service from provider	Competition for a market as a substitute for competition in the market	Bureaucratic inefficiency Monopoly may prevent new bidders from entering the market
<i>Self-regulation</i> Regulation by professional association	Medical association enforcing standards of conduct	Do the public trust enforcers Incentive to be enforced must be collective? Danger of regulatory capture.	<i>Incentives</i> Inducements for good behaviour	Permitting private practice, internal competition	Fails to prohibit offence Poor response to problems arising from irrational or careless behaviour Measuring outcome is difficult.
<i>Licensing/ accreditation</i>	Regulation of health facilities or personnel to ensure that they meet a certain standard Control through internal market competition	Information may not be available to everyone	<i>Disclosure</i> 'naming and shaming' of offenders	Public opinion surveys	Requires a viable alternative, a public acceptance that payments are not beneficial
<i>Contracting</i> Purchaser (government) acquires	Combination of diffusion of standards and provision of service	Limited public accountability Information gaps	<i>Rights and liabilities laws</i> Statement of patient rights that are protected under law	individual, private settlement may be more attractive as costs of enforcement are often high Individuals may lack information	Places onus of regulation on the

Source: Entsor and Weinzierl (2007:356-357)

4.3. Brief historical outline of regulation in health care in USA

Jacobson (2001:1167) doubts that there was any regulation in the health market before the year 1965. He claims that the establishment of Medicare and Medicaid in the year 1965 dates the dawn of the first real regulatory activities in health care system in USA. Looking backwards to the year 1965, the health care system was in power of private companies of doctors. The author mentions that there might have been non-federal-based regulation. However, he seriously doubts it. Principal regulatory action was made via state licensure amendments, which primary provided complex control over doctors and nurses. As a consequence, the medical profession

seemed to be self-regulating, which has principally been perceived as failure of the market. (See Jacobson, 2001:1167)

In 1963, the doctors' regulation was concentrated on the quality of relationship with the patients. The cost constraint was not an issue. Due to the lack of other non-market social organizations that take care of reducing the information asymmetries as well as monitoring the service quality, it all relied on the ethics of doctors. (See Jacobson, 2001:1167-1168)

In 1972, the so called "physician regulation", began to fail. In 1965, as already written above, it is on the basis of Social Security Amendment that two programs were established: Medicare and Medicaid. At first, this law covered the health insurance for people over 65 as well as the poor. (see www.medicare.gov)

Starting from 1965, the country authorities were provider, insurer, purchaser as well as regulator. The change was enormous. The health care became a system. In 1963, a big malfunction in the health market was observed. In 1970, there was a government intervention regarding "a profusion of federal rules and regulations to control health care delivery." (Jacobson, 2001:1168)

In 1970s, there were many agencies, which were offering their accreditation and setting certain standards for health service. One of them was the Joint Commission on Accreditation of Healthcare Organizations, later mentioned as JCAHO. (www.jointcommision.org)

It was the beginning of 1990 when National Committee for Quality Assurance (NCQA) offered their guidance. Jacobson (2001,1168-1169) questions who can effectively face the market failure. Between government and self regulation, he point out that neither of them could. Regarding access, he states that not everyone has it and this issue is hardly to be addressed. Concerning the costs, the question remains if the government or private sector should run the cost control. There is one more issue,

namely the excellence of service; should the control be left to the government or the market itself?

4.4. Prospective Payment System

In order to follow this section, it is essential to answer two questions. What is the difference between prospective and retrospective reimbursement? Medicare system has switched from retrospective to prospective system (Chen and Shea, 2000)

Prospective reimbursement is “a method of payment to an agency for health care services to be delivered that is based on predictions of what the agency's costs will be for the coming year.”

(See <http://medicaldictionary.thefreedictionary.com/prospective+reimbursement>)

It means that the payment is in advance for incurred costs, unlikely to retrospective reimbursement where a person covers the costs himself or herself and after applies for the coverage. It was actually hospitals that presented the bill to Medicare after the treatment of patient. Folland et al. (2007:438) questions the incentives to control the costs in this system.

Another term is prospective payment system. This system is one of reimbursement for inpatient health care, in which there exist already predetermined fix rates that depend on the sickness. It means that the actual costs that hospital has to spend do not matter for the calculation of reimbursement fee. Therefore, the application of the prospective reimbursement lowered the hospital revenues, calculated per patient of Medicare. As a consequence, it is not in the hospitals' best financial interest to provide long “unnecessary” treatment.

(See <http://medicaldictionary.thefreedictionary.com/prospective+payment+system>; also Folland et al., 2007:433)

Before the PPS, there was the Tax Equity and Fiscal Responsibility Act (TEFRA) from 1982. Davis et al. (1990:35) emphasise the significance of TEFRA, namely the budgetary savings as well as the conceptual and methodological characteristics later used in PPS. Medicare PPS assumes the same rate for every single medical diagnostics. (Davis et. Al. 1990:39)

Folland et al. (2007:439) groups the Medicare payment system into six separate segments. These are:

- ⇒ Acute care on inpatient basis (this care is provided by short-term general and also psychiatric hospital);
- ⇒ Nursing facilities that offer post-acute health service (post-acute service also includes home health agencies, rehabilitation places, as well as long-term hospitals stays);
- ⇒ Ambulatory care (this service is provided by general doctors, in hospitals as well as labs);
- ⇒ Special care for diabetics, namely dialysis service;
- ⇒ Ambulance service; and
- ⇒ Medicare Advantage program, which is private health care service.

Folland (2007:439) states patients are matched on the basis of one of the DRGs that is applicable. The complete list of current DRGs could be found on the website of cms, which is available under

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/downloads/DRGdesc08.pdf>

In accordance with this data (accessed on 7th December 2012), there are 989 DRGs, whereas in 2005 there were only 504 (Folland et al 2007:439).

Each single DRG has its own weight. This weight presents the typical amount of resources for a typical Medicare patient in DRG, in relation to all patients of Medicare. (see <https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf>)

The higher the weight of DRG, the higher the cost of treatment.

4.5. Regulation of hospitals

In the 1960s, a cost-based health care payment system was introduced. The costs were going up abruptly, also due to creation of Medicare and Medicaid. The budgets of the country as well as states were under the demand of regulation.

Many states set the regulatory controls regarding the hospital investment when it was not very common to establish the hospital price regulation amendments. (Salkever, 2000). At the beginning, the rate of regulation was made on the basis of hospital costs. This calculation of the rate was accepted by the state. (See Folland et al., 2007:432)

It has changed in the 1970s when the inflation has reached its peak. As a consequence, the regulation of prices on the federal level became an issue (See Economic Stabilization Program from 1971).

There are three most important types of hospital regulation, namely rate regulation, utilization review as well as the CON. These forms will be reviewed in the next subsection of this part of the paper. The quantity could be controlled by the certificate law, for example by Certificate of Need law (CON). The quality is controlled by utilization review (UR).

4.5.1. Rate regulation

Rate regulation (also called RR), as mentioned before, outlines the conditions of hospitals' reimbursements. It was introduced as a consequence of market power, and the option of charging too high/low costs for services and generally the inefficiency. The aim of RR is cost reduction and/or diminishing the rate of hospital cost inflation. RR can be related to daily, per patient or per admission basis. (Folland et al, 2007:433)

Usually, this method is designed on the basis of a regression analysis:

$$\log C_{t1} - \log C_{t-1} = b (X_t - X_{t-1}) + dD + \epsilon$$

Source : Folland et al. 2007 :434

The left side presents the change in expenses of hospital (in percentage) which equals the explanatory variables X plus the “D” (imposing the regulation rate).

4.5.2. Utilization Review

UR controls the intensity as well as the costs of the service. It is reviewed if the costs can be calculated lower and where will be no bad influence on the health of each of the patients. There are, however, some concerns regarding the lack of harm. There is a danger that a patient receives less care and, as a consequence is uncertain about getting good results.

4.5.3. Certificate of Need

The CON forces hospitals to obtain acceptance for the amount of treatments, extending the existing facilities, and what follows it, expenditures. This approval is given by planning agencies. This legislation, after being studied by various experts, seems to have a slight influence on planning the expenditures (Folland, 2007:436).

What CON looks for is to decrease the capital expenditures. Before the construction of any facility begins, it has to be approved at first.

(See <http://www.health.ny.gov/facilities/cons/>)

Recently, CMS has introduced an incentive payments program for hospitals which fulfill the quality standards of health care performance. It was approved by ACA. (see <http://www.healthreformgps.org/resources/cms-releases-final-rule-on-medicare-payment-systems/>)

4.5.4. Implications of hospitals' regulation

Salkever (2000) mentions the implications on hospitals' regulation. He states that regulation turned out to be the most efficient tool, more efficient than "provider capture" causes. Salkever (2000) also emphasizes that the influence of cost-containment of health care was not stable across years, which affected the national policy. The author also doubts that the impact on investment controls brings lower rate of cost growth. In his opinion, the PPS system limits the costs, but there seem to be unanswered questions regarding the efficiency of PPS and adequacy of the model.

5. Conclusions

In this thesis, the reader could get to know what the regulatory mechanisms in the health care system of USA are. The paper mentioned the past, present and future perspective of the health system. There were also limitations that were addressed. We have seen how the health system was established throughout the years. Furthermore, the forms of intervention of the government in health sector were reviewed. One of the forms is regulation. Diverse forms of regulation were brought to analysis along with the example of mathematic formula. We have seen how the welfare loss looks like and why the regulation is necessary. There were also some critical approaches presented.

Medicare and Medicaid systems were analyzed. Moreover, the reader could see what the structure of health care expenditures in USA and its relation to quality of care are. Unfortunately, even though USA spend the most for health care in comparison with the rest of the world, there are still plenty of drawbacks in the system. The rising hope is the health care reform that proposes a long term plan addressing major problems. We have found out why the USA healthcare system needs help. It seems that USA and England face similar problems with health care. The main improvements are: cautious medical expenditures (at around the level of the growth of GDP) and encouraging quality of the service by providers. Up to Obama's reform, the system was inefficient, inequitable. Almost 18% of GDP of USA which consist of half of public expenditure budget falls into health care that is unable to provide insurance for 1/6 of the population (See Blumenthal and Dixon, 2012:1352). Another urgent issue is that Medicare grows and what follows, its shortages in budget, which are forecasted to reach over \$660 Billion in the year 2023 (also see Journal for Health Care Practice and Risk Management, 2009). After conducting the reform, the health service will become a real public good, more available and affordable. Let us hope that this intervention will bring more efficiency and better quality in health care of USA.

6. Abstract

In dieser Schrift werden die Regulierungsprobleme des Gesundheitssystems sowie die Formen der Intervention der Regulierung in den USA näher besprochen. Der Leser hat die Möglichkeit die Geschichte des Gesundheitssystems in den USA zu lesen und dessen Entwicklung zu beobachten. Die Wichtigkeit der Regulierung sowie Formen der Regulierung wurden analysiert. Der Leser hat auch die Möglichkeit die Struktur der Gesundheitsmarkt anzuschauen. Die Verteilung der Kosten für Gesundheit ist auch ein großes Thema der Arbeit. Die Reform des Gesundheitssystems und dessen Vorschläge sowie Kritik wurden analysiert.

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Curriculum Vitae

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Personal Details

Date of birth	September 24, 1986
Nationality	Polish
Marital status	Single

Summary

- Graduate Student / International Business Administration / performance-based scholarship
- International and intercultural experience / ready to travel
- Sociable, eloquent in English, German, French and Polish
- Proven cooperation skills

Education

03/2011 – 12/2012 (expected)	Vienna University Master of International Business Administration ▪ <u>Specialisation in:</u> ▪ International Management, Business Communication in French, Public Utility Management ▪ Master Thesis subject: Government regulatory actions in health care sector with special focus on USA ▪ GPA: outstanding (performance-based scholarship)	Vienna, Austria
03/2008 – 01/2011	Vienna University Bachelor of International Business Administration (Continuing the education started in Warsaw) ▪ <u>Specialisation in:</u> International Management	Vienna, Austria
09/2007 – 02/2008	Otto-Friedrich University Erasmus Study Abroad Program ▪ <u>Specialisation in:</u> Globalisation, International law, Environmental Marketing	Bamberg, Germany
10/2005– 09/2007	Warsaw University Study Programme: Management	Warsaw, Poland
05/2005	Matura (Polish School Leaving Certificate)	Warsaw, Poland
09/2002– 06/2005	Johann Wolfgang von Goethe High School	Warsaw, Poland

Awards

07/2012	Performance-based scholarship	Vienna, Austria
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Internships, Professional Experience

19-20.10.2012	Facilitator of the event <i>Students4excellence GmbH</i> ▪ Support to the staff in organization of the event	Vienna, Austria
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From 03/2011	Student Assistant (14 h / Week) <i>Vienna University, Department of External Accounting and Tax Law</i> - Preparation of courses at Vienna University and external lectures - Support to the university staff in organization and research - Student support - Administrative tasks	Vienna, Austria
07/2010 – 10/2010	Internship: Office Manager (40 h / Week) <i>Cech Krawców i Rzemiosł Włókienniczych</i> - Organisation of the office - Preparation of events - Marketing tasks	Warsaw, Poland
07/2009-10/2009	Sales assistant (40 h / Week) <i>Triumph International;</i> - Customer's service, advisory tasks - Product purchase, administration of the budget	Warsaw, Poland
01/2007 – 09/2007	Internship: Marketing and administrative assistant (30 h / Week) <i>Graal, Barbecue Restaurant;</i> - Development and evaluation of marketing objectives - Administrative tasks - CEO support	Warsaw, Poland

Other tasks to finance the education

05/2008-02/2011	Language support (10 h / Week) - Translation of the texts from German to English - English conversations and classes with adults and children	Vienna, Austria
09/2010-02/2011	Babysitting (10 h / Week)	Vienna, Austria

Further training

10/2011-10/2010	French course level A1-B1 Vienna University	Vienna, Austria
27.04.2011	Deloitte Workshops: Tax advisory, Consulting	Vienna, Austria
27.05.2010	Procter & Gamble Workshops: Marketing	Vienna, Austria

Experience Abroad

02/2010	Language and culture study trip	Montréal, Canada
02/2009	Language and culture study trip	Joliette, Canada
09/2007	Language and culture study trip	Bamberg, Germany
07/2002	Language and culture study trip	Hastings, England

Additional Information

Languages	Polish: Mother tongue English, German Excellent French: Good knowledge (level B1, Vienna University courses)	
IT	Excellent in: MS Office , Internet Browsers such as Internet Explorer , Mozilla Firefox , E-learning platform Moodle Basic knowledge in HTML , Java Script , SPSS	
Driving license	category B, also valid international driving license	
Hobby	Jogging, Cycling, Travelling, Cooking	

Wien, 23. November 2012