Quality Management
for Health Sector–a Comparative Analysis of German and Polish Experiences

Gunnar Prause, Prof. Dr.
Hochschule Wismar, Germany
Iga Rudawska, Dr.
Uniwersytet Szczeciński

I. Introduction

The structures in the European health sector are in motion due to the exploding health costs, the legal situation of the involved institutions and the demographic development. Since agreements of states in the European Union do not apply to the social sector the structures of the social landscape depend on the specific situation of each nation. Focusing on continental Europe one can observe that the largest part of the health market is part of the public sector, which means that the majority of the sanitary institutions are public owned and that also the majority of the population is a member of a public health assurance.

Despite this nation oriented situation there are big efforts of the governments to introduce market-oriented concepts into the health sector to support the actual lacking competition between the health institutions. These efforts are specially focused on the hospitals because they absorb about 1/3 of the whole public health budget. One major approach in this process is to emphasize quality standards to be able to evaluate the performance of the hospitals and to find a basis for an adequate payment for the hospital services.

By going more into details it turns out that there is no unique solution for a quality standard for hospitals. The practical experience reveals that a number of quality approaches are available but all of them have their own intentions and not all of them can be adopted without problems to the situation of a hospital. In this paper the authors present the actual situation of the quality management in the hospital sector in Germany and Poland and try to explain the concepts and the aims of both governments to implement suitable for quality standards in the hospital field of their nations.

II. The German situation

1. Facts about the German health sector

The financial situation in the public health sector forced the German government in the 90's to change the payment for the about 2400 German hospi-

tals. The economic and demographic background of the situation in the German health sector should be explained by the following figures:

Table 1.

Figures describing German health sector

Population	82 Mio inhabitants
Average age per inhabitants	2000: 40,9 years 2040: 48,4 years
Percentage of inhabitants older than 65 years	2000: 13,3% 2040: 21,3%
Years of life expectancy for men/women	74,5/80,5
Average of annual real growth of the BNP between 1990–2000	1,5 % per year
Health expenses in % BNP	10,6%
Average of annual real growth of the Health expenses between 1990–2000	3,5% per year
Hospital beds per 1000 persons	7

Source: *2001—Deutschland in Zahlen*, Institut der deutschen Wirtschaft, Köln 2001.

From these figures it is obvious that the German society can be characterized as a mature industrial society with a growing percentage of older people where the expenses of the public health sector are increasing faster than the BNP. Moreover, the OECD figures[1] reveal that in the European context the German health sector represents an inefficient model because the high health expenses are yielding only an average result by taking the life expectancy as a measure for its performance.

As a first consequence the government reduced the over decades used principle of full cost covering. It was modified at the beginning of the 90's towards a case related payment. As only up to 20% of the whole services of a hospital where paid by case related prices, the effects of the cost reduction plan of the government failed. As a consequence the budgets of the hospitals were frozen on the level of 1993. This caused a steady decrease of number of beds per hospital and parallel a fall of the duration time per patient from an average of 15 days to an actual average of about 9 days per patient. But still these measures were not able to cut the costs in a sufficient way.

Another important constant in the German hospital sector is its public structure that realizes a mixed management involving political and economical aspects. The main legal construction for taking regard to the political as well to the economical aspects consists of the principle of dual financing of the hospital sector, which means that all investments with an economical lifetime of more than 3 years are financed by the state governments whereas all operating cost, including investments up to 3 year, are paid by the health assurances. This split financing allows the political state governments to decide the locations of hospitals and their spectrum of services whereas the health assur-

[1] OECD Health Data 2003.

ances are keeping track of the efficiency of the service processes of the hospitals. Since the majority of the hospitals are public owned, mainly by the communes, and the majority of the assurances are as well public incorporations nearly all involved parties in the German hospital sector are members of the public sector. One main consequence of this situation is a very strong role of the unions of employees and the association of doctors which makes fundamental structural changes in the hospital sector nearly impossible.

2. Quality management in hospitals

In order to be prepared for the upcoming competition some German hospitals decided early to start the total quality approach before the law forced all hospitals to apply quality standards. The chosen quality standards were mainly based on the industry standards ISO9002 and EFQM where the auditing companies to the hospital needs adapted these norms. The experiences with these modified standards were relatively poor because the modified norms were not able to reflect adequately the hospital situation. One main problem was the lacking knowledge of the auditors in the hospital sector (they mainly came from the industry sector).

A general demand for the implementation of a quality management standard for German hospitals does not exist. In the medical sector there are some strong obligations for realizing a high medical quality standards in surgery, diagnostics and therapies but a more hospital oriented quality approach is still to come. Like for instance in Great Britain (ca. 30 different quality standards) and other European countries there is a big variety of different used quality standards for those hospitals that are voluntarily willing to introduce a quality system. Only Italy and France are the two European countries enjoying a nationwide unique certification in quality management that is compulsory for all hospitals. In pilot projects the most frequently used quality standards in Germany are: EFQM (European Foundation for Quality Management), Joint Commission, KTQ (Kooperation für Transparenz und Qualität im Krankenhaus), QMK (Qualitätsmodell Krankenhaus), ISO9000ff, AMIQ and ASKLEPIOS-Modell für integriertes Qualitätsmanagement. All these standards, adapted to the special hospital situation, look similar by the first consideration because all of them emphasis the care of the patients along the medical pathway. All other sectors of the hospitals operating business like the general management, the personnel management, the information management and the management of the hospitals environment are activities of the second row comparing to the patient care. A recent poll in the state of Hessen revealed that 76% of the hospitals have created a position of a coordinating quality manager where the used quality management models in the hospitals have an unequal distribution with the leading position of KTQ-model[2]. The mentioned poll only reflects the situation in one federal

[2] "Qualitätsmanagement", *Sonderheft* 6/2001, Baumann Fachverlag 2001, s. 12.

state but it gives already the first impression of the quality situation in the whole nation. So it can be stated that the implementation of quality management systems in German hospitals is a task that has already reached the majority of the hospitals but it still has to be realized in ca. 1/4 of all hospitals.

3. Differences and cross walk in quality management

By investigating the reasons for the success of the German KTQ-model there must be mentioned some important advantages for the hospitals for preferring the KTQ-approach:

— Low auditing costs.
— All quality examination ends with a certificate.
— Underlying concept supports a continuous improving process.
— No consideration of the hospital results.
— Agreement of all important parties in the health sector.

To understand more precisely the underlying structure of the KTQ-model we compare the KTQ-model with the more common quality models. In a project of one of the big privately owned German hospital chains, the ASKLEPEPIOS KLINIKEN GROUP, with 64 hospitals all important quality standards were implemented simultaneously[3]. For all quality approaches there is a common basis consisting of evaluation instruments for the universal economical criteria: Capability criterions (Management, Employees, Strategy, Partners & Resources, Processes) and Result oriented criterions (Personnel oriented results, Client oriented results, Company oriented results, Results of the main processes).

One important tool for comparing the different quality models was the use of crosswalks to work out the characteristics of each standard. In the form of matrices the crosswalks show the differences in each criterion between the two different models. One main result of the crosswalk analysis concerns the orientation of the different quality models:

— EFQM-model: considering both the capability criteria and the result oriented criteria.
— KTQ-model: concentration on the capability criteria.
— Joint Commission:
  JC-standards: concentration on the capability criteria,
  JC-ORYX: concentration on the result oriented criteria.
— QMK-model: concentration on the result oriented criteria.

By focusing on the two German quality approaches the KTQ-model and the QMK-model there is no big surprise which institutions are responsible for the creation of the standards. The KTQ-model was developed in cooperation between the public assurances, the association of hospitals and the association of medical doctors. There is a big emphasis on the structures and processes of the hospital by neglecting the result oriented criteria due to the 2/3

[3] Ibidem, p. 23.

majority representing the hospital employees in the quality committee. The alternating QMK-model is a creation of the largest German health assurance (AOK) and two private hospital chains so there is also no big surprise that this approach is stressing the result oriented criteria because of the economical view of the assurances. As a conclusion we see two complementary quality models where each concept reflects the preferences of its creating institution. To enjoy the advantage of both quality concepts the KTQ and QMK and to integrate own ideas in quality management some institutions mainly hospital chains create their own quality standards like the AMIQ-model of the ASKLEPEPIOS Group that represents a synthesis of the most important hospital standards in quality management.

In the case of the KTQ-model we present a closer look to the emphasis of the underlying quality criteria to underline our observation. By comparing the EFQM, the KTQ and the ISO9000 standards we get the following diagram that supports the comments on the orientation of the KTQ-model.

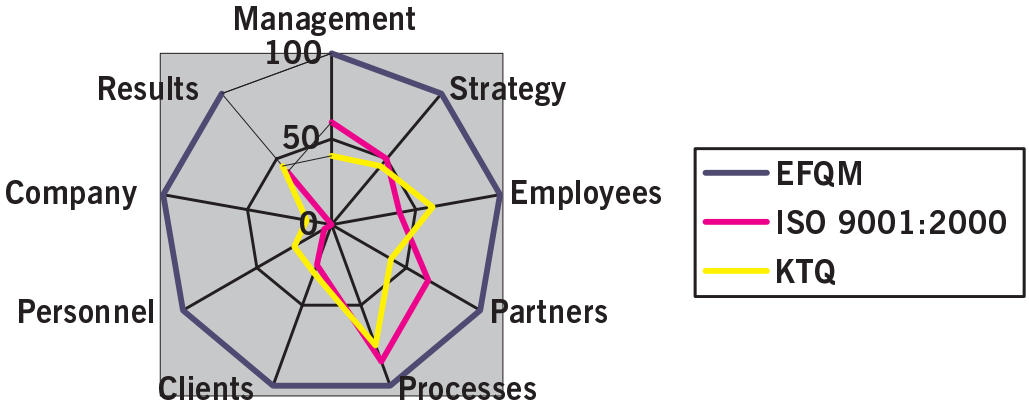

Figure 1.

The comparative analysis of three competing standards of quality

Source: *KTQ-Katalog—Version 3.0*, Deutscher Krankenhaus Verlag 2000.

The diagram visualizes the emphasis on employees and processes where the main economical criteria are neglected. Also the lack of intention on the hospital economical environment like partners and clients are surprising facts, which are in contradiction to the fundamental quality approach in industry where an important argument of the initial quality debate was the possibility of creation of processes that passes the borders of several companies. This concept of creating virtual process structures in the health sector is not previewed in the KTQ-model. This is an reflection of the strong political influence in the German hospital sector where the local health situation is often more dominated by local political interests than economical arguments.

To understand more precisely the underlying ideas of the KTQ-model we compare it with the EFQM-model. The KTQ-evaluation follows a catalogue of questions consisting of 6 categories, 22 standards and 70 criteria, all focused on the demands in the field of hospital management (EFQM: 9 criteria and 32 subcriteria). The certification philosophies differ between the continuous improvement process used by the EFQM-standard and the "good-enough--model" used in the KTQ-standard. A closer look into both of the two standards by using crosswalks reveals the following observation:

Table 2.

The comparative analysis between EFQM-model and KTQ-model

Criterion	EFQM	KTQ
Quality of the structure Process quality Quality of the results	+	No consideration of the quality of the results
Development based on hospital needs	Applies to all branches Not only focused on the health sector	+
+	Comprehensive management tool	No management approach No regard to expectations of partners, owners and other companies
Points are calculated for a certain moment Unlimited validity of the certificate	Time limit of the certificate	+
+	Continuous improvement	Certificate states that standards are fulfilled No statements about improvements

Source: *Aktuell 2001*, Hardenberg Verlag 2001.

The table 2 also shows that the KTQ-approach is not focused on formulating a quality management system for the hospital management. The main target is rather to state the actual degree of realization of the quality standards formulated in the catalogue of questions.

4. Introduction of DRG

But the German quality debate is also influenced by another source due to a new pricing system that is due from the beginning of 2003—a nationwide unique prices for all hospital services in Germany. This new pricing system is based on the Australian System of Diagnosis Related Groups (AR-DRG) and the German DRG-system is adapted to the German situation. To coordinate the activities around the German DRG-system the government founded a new G-DRG-institute that got the task to calculate the starting prices for all the

hospital services. After the implementation of the new G-DRG-system the hospitals find themselves in a target costing situation where a fixed price is paid for a special service whether or not the induced costs for the case in the hospital are covered or not. Since the hospitals are not free to fix their offered medical services (each state government fixes its own hospital plans) an effective process and cost management needs to be implemented in all hospitals.

But with the new pricing system the quality question gets a new importance. Already in the old pricing system where the payments for hospital services were supervised and controlled by a public medical revision authority (MDK: Medizinischer Dienst der Krankenkassen) there has been a lot of conflicts between the public health assurances and the hospitals about the need of special medical treatments and the time of patients' stay in hospitals. These conflicts ended very often in trials nearly always touches the question if the time the patients stayed in hospital was too long as stated by the medical revision authority or not as stated by the hospitals.

The new G-DRG-system will reverse the conflict between the hospitals and the medical revision authorities into the question if the stay in hospital was long enough to guaranty a certain quality level or not. So the enforcement of quality standards and measurements of the medical quality level in the hospitals is the crucial question for the success of the new G-DRG-pricing system.

5. Conclusion to the German situation

The German approach in quality management for hospitals is dominated by the new developed KTQ-model that was created in cooperation between the most important institutions of the national health sector. In the case of KTQ these are the public assurances, the association of hospitals and the association of medical doctors. Since the major part of the German health sector belongs to the public sector with a mixed responsibility of the political level, namely the state governments, and the economical level, represented by the public assurances, these four groups are dominating the public health discussion. As a consequence the interests of these four groups are obvious in the KTQ-model.

But also the big influence of the political sphere on the hospital sector is an important obstacle for concentrating on the economical needs of the whole German health sector. As shown in the analysis the competition between the hospitals can only be realized on the quality level due to the nationwide unique pricing system. But despite this situation the quality competition is slowed down by neglecting result oriented criteria and by refusing to implement powerful tools like benchmarking instruments making it possible to compare different hospitals and their economical performance.

III. The Polish situation

1. Facts about the Polish health sector

During the post–1989 era, Poland implemented macroeconomic reforms supplemented by institutional changes and enactment of new legislation aiming to complete the transformation at different paces. As for the health care sector, policy implementation is a function of the political will. Governments were short-lived, which led to different reform proposals being considered. Nevertheless, the most significant approach was to replace the old, based on general revenues system with the new one. The legal bases of changes in the health care system are:

1) the Law on Health Care Facilities (1991), on the basis of which public and non-public health care facilities can be established;
2) the Law on the Occupation of Doctor (1996), on the basis of which individual medical practices, specialised medical practices and group practices, being a new organisational form of out-patient health care, are created;
3) the Law on the General Health Security (1997) valid since 1999 to April 2003, on the basis of which the regionalisation of health care services was eliminated and the insured have the right to select both the sickness fund (one of the 16 Regional Sickness Funds or the Branch Health Fund for the Uniformed Services) and a primary care doctor;
4) the Law on the General Health Security in the National Health Fund (2003) valid since 1rst April 2003, on the basis of which the 16 Regional Sickness Funds were replaced by one centralized Fund[4].

The purchaser-provider relationship is regulated through the individual contracts. The majority of health care provision is covered by public sector (90%). Insurance premium is calculated as a flat percentage of income (8,75% —2004) and is equal for every citizen. Direct out-of-pocket payments by patients at the point of service constitute a limited but significant portion of total health care financing. It refers to services provided out of contract (both in public and private sector) or prescribed by doctors working on their own.

The starting point for health sector analysis is the macroeconomic and demographic environment (tab. 3).

The implications for health services of the macroeconomic and demographic environment are quite considerable. The ageing population increases need for health care, which has important resource consequences. This is compounded by falling birth rate, so that the number of working people able to contribute to health care funds decreases. Economy of Poland is characterized by slow growth rates combined with high unemployment. This creates the pressing need to keep public expenditure under strict control. Yet the evidence suggests that the system is underfunded, resulting in poor

[4] In January 2004 The Tribunal claimed that the Law on The National Health Fund did not conform to the Constitutional Law. By 2005 the imperfect Law is to be replaced by new one.

quality of care. The health sector in Poland faces serious problems referring to both hospital facilities and medical equipment. Hospitals are deemed to be too old and ill equipped and capital expenditures are insufficient to support existing facilities or introduce new technology. At the same time, the acute hospitals constitute the largest single component of health expenses. Under these circumstances the need for cost containment and micro-efficiency are high on the agenda of policy makers.

Table 3.

Basic statistical data about health sector in Poland

Population	38,6 Mio inhabitants (based on census data 1995)
Non-working age population per 100 Persons of working age population	65
Years of life expectancy for women/men	78,4/70,2
Δ BNP:	1,1% (2000/2001)
Health expenses:	10,8 Billion € (i.e. ca. 7% BNP)
State budget expenses for health care:	ca. 4,5% BNP
Predominant approach to financing operating costs in hospital sector:	based on hospitalization and procedures
Total number of hospitals:	736 (including 45 non-public ones)
Beds ratio (per 10,000 persons)	48,7
Physicians ratio (per 10,000 persons)	22,4
Average occupancy rate in hospitals	74,6%
Average length of stay in days	8,4

Source*: Rocznik Statystyczny RP*, GUS, Warszawa 2002.

The major effect of health sector Reform of 1999 has been the shift from a global budgeting system to the contracting one as a means of paying for hospital services. Nowadays the regional branches of the Fund act as the purchasing agent of hospital services and enter mainly into cost/volume contracts. While there is considerable variation in how hospitals specify services and estimate prices, the hospitalization is commonly used as a unit of payment. In that case hospitals tend to maximize patient length of stay, which in the long run is not effective. Nevertheless, until now there has been no debate over the adopting measures to expedite discharge once the patient has recovered (i.e. target-based systems such as the DRG or other case mix systems).

2. Quality management in hospitals

Although there is a general recognition of the need to improve current approaches with a view to enhancing efficiency and performance-related incentives within the hospital system, quality improvement techniques are

rather poorly developed. In Poland there is only one state institute dealing with quality control programs. Only a few hospitals, e.g. 8% of a total number decided to apply quality management. The main reason for it is a poor recognition of quality standards by payer (Sickness Funds and The National Health Fund).

Having neither tradition nor experience in quality management Poland has adopted two health care quality standards: ISO 9002 and Accreditation System. They refer to both public and private sector. The first one has been applied to a very limited extent. The approach proved to be difficult to adjust to health care sector. Health care organisations, which apply for a certificate, have to redefine the criteria included in ISO norms and adjust them to the health care environment. For example, the term *crisis situation* has been interpreted as a *patient's state of life hazard*, the term *service* refers to *community aftercare*. The drawback of this method is that the broad interpretation of particular criteria does not make standard evaluation among health care organisations possible. The costs of preliminary audit proceedings and gaining a certificate amount to approximately 10,000 €. Moreover, a hospital applying for ISO certificate has to cover all expenses concerned with possible auditors' training and investment necessary for meeting the norm requirements. In that case in 2001 there were only two hospitals in the programme[5].

The model, which appears to have broader application in the health care sector, is Accreditation System based on American experiences. It was introduced in Poland in 1997. The Hospital Accreditation Programme has been prepared by the Centre of Quality Monitoring in Health Care—state institution within the structure of Ministry of Health Care. The Programme is based on several principles (tab. 4):

Table 4.

Principles of Accreditation Programme

1. Voluntary participation	A hospital applies for an accreditation of its own free will
2. Standards	The evaluation consists of a comparative analysis of actual state of a hospital with an ideal one expressed in standards
3. Educational scope	During an accreditation visit experiences are interchanged
4. Autonomy	Accreditation allowance is free of particular interests
5. Proceeding according to procedure	Evaluation is conducted in accordance to defined and known pattern
6. Openness and equality in valuation and decision making	All hospitals entering Accreditation Programme are subject to universal valuation principles

Source: Piotrowski M., R. Niżanowski, "Akredytacja a prawa pacjenta", *Zdrowie i Zarządzanie*, Tom III, nr 2, 2001.

[5] "Jak uzyskać certyfikat", *Gazeta Medyczna*, nr 2, 2001.

The Hospital Accreditation Programme is based on 210 standards divided into 15 following groups: General Management, Human Resources Management, Information Management, Infection Control, Patient's Rights, Valuation of Patient Condition, Patient's Care, Anaesthesiology, Drugs, Diet, Continuity of Care, Quality Improvement, Environment of Care, Admission Room and Laboratory. Standards fulfilment is evaluated in point scale with 1–5 range where 5 is the maximum level. They are subject to periodical modification depending on a rate they lead to satisfactory result. In order to receive a full accreditation for three years a hospital has to achieve at least 75% of the maximum score. The result in the range 70–74% entitles to receiving conditional one-year accreditation. After 7 years since the Programme was introduced 59 hospitals obtained accreditation (57—full, 2—conditional—01.01. 2004 data[6]).

One can assume that Hospital Accreditation Programme should yield benefits for patients, hospital itself as well as the whole region. As the practice shows, patients are those participants who benefit the most. They receive better, safer and more comfortable services. The evaluation of benefits in the remaining areas proves to be much poorer. In the majority of cases accreditation has not led to gaining public recognition or changing the policy of regional health care authorities towards the best hospitals. The same refers to The Fund, which does not take into consideration the fact of getting the certificate by a hospital while contracting services. Regional health care authorities tend to evaluate service quality not in the light of hospital's achievements confirmed via the accreditation certificate but rely on medical statistics. Hospital founders, in most cases i.e. local government, also do not recognise and praise the effort one hospital carried in the accreditation process.

Opinions gathered in the field research conducted on a group of hospital staff engaged in accreditation process point at several problems they face[7]:

poor involvement of many co-workers in the accreditation process and even lobbing against it,
— a lot of additional papers to fill in,
— shortage of financial support,
— not enough time for preparation to a visit,
— poor technical condition of equipment and facilities.

On the other hand the most satisfying for them was that:
— their hospital obtained the certificate,
— patients and their families were pleased with the changes,
— they could take part in preparation of the procedures,
— there were additional workshops and training,
— hospital image in the local community has improved.

Relying on these opinion one can draw the following remarks:

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[6] www.cmj.org.pl.

[7] M. Mikietyński, J. Wacław, "Po co szpitalowi potrzebna jest akredytacja? Refleksje pracowników Szpitala Wojewódzkiego w Koszalinie", *Zdrowie i Zarządzanie*, tom III, nr 3–4, 2001.

1. Accreditation proves to be an efficient method of quality management; it yields many benefits, especially in the organisational dimension. The most often mentioned advantages compound: more effective work, costs reduction, easier identification of areas to be improved and better awareness of hospital staff in terms of medical machines control, in-patient infection control, standardisation and implementation of hygiene procedures.
2. Accreditation contributes to changing the way work and patient are being perceived by hospital staff; personnel becomes involved in the problems the hospital faces and wants to be involved in their solving; in case of a process being repeated, it yields benefits in the area of creating new corporate culture with positive thinking towards hospital mission, patients and co-workers.
3. The main beneficent of the accreditation process is the patient who receives better services.
4. Accreditation can be used as a promotional tool in attracting new patients.
5. The most crucial problem on the way to accreditation is shortage of additional financial means.

3. Patients' quality control initiatives

The principles of the communist health care system denied individual rights. Patients were considered passive objects of the system whose treatment was differentiated according to their status in the ideologically determined state hierarchy. Nowadays, the importance of the individual as the subject of the health care system is raised. The regional branches of The Fund are increasingly acting as representatives of patients' interests. They set up special units that are responsible for settlement of patients' claims. Moreover, complaints procedures for patients exist within the system of professional self-regulating associations. Users may also voice their dissatisfaction through a patient support group "Primum Non Nocere". This positive evidence can be attributed to moving from input-based allocation of resources to contracting mechanisms, new information requirements and decentralisation of management.

4. Conclusion to the Polish situation

Regardless of which quality management method has been implemented, in Poland they are at its initial phase. Hospitals, which entered pathway towards quality improvement, can be named pioneers of the process. They try to develop marketing orientation opposite to the product orientation dominating in the sector. In most cases however, hospital managers make many mistakes, which obviously influences the process of quality improvement. The most evident one concerns permanently maintained and emphasized opinion that shortage of money makes quality improvement impossible. In that case one should remember words of Japan expert Ishikawa who claims

that 95% of all corporate problems can be solved by easy tools. The second biggest problem refers to imperfect means allocation. The main reason for such situation is that doctors not professionals manage the majority of hospitals in Poland. They have scarce working knowledge of economy and no managerial skills. They focus on medical dimension of service quality and often ignore others, which as well contribute to quality making process. The same refers to quality control. They concentrate on single therapeutic out-puts of the particular departments regardless of holistic, interdisciplinary approach. Moreover, it is a commonly of shared opinion that expenses rationing and cost reduction can encroach upon interests of particular groups (mainly medical staff). Any change in the work organization is perceived as threat of their status quo. Such a situation can result in corporate conflict, which obviously does not support quality management. On the other hand, those of staff members who would like to take part in quality management adoption are often under-appreciated. It refers particularly to nurses, whose subordinate position makes co-operation for quality improvement very difficult. Even if they get involved in the process they may quickly become disappointed as they do not see a direct link between changes adopted and improvement of work conditions i.e. pay-rise, better equipped work station etc.

Another characteristic of approach to quality management in Polish hospitals is that it is often applied only in emergency. No wonder that such fragmentary and unsystematic actions do not result in quality improvement.

Last but not least, Poland entered the EU, which may suggest that, apart from macroeconomic indicators, health care sector will be closely monitored and continually evaluated. This also implies that hospital system performance should be one of the areas requiring attention by the government. The quality management becomes critical in this respect.

IV. Résumé

The European hospital sector is in motion due to the exploding health costs and the demographic development. Since the treaty of the European Union does not include the social sector each of the European countries has its own social system that represents a part of its own national tradition. For continental Europe this means that the biggest part of the social system is part of the public sector. Specially in the hospital sector this means that main players like the hospitals and the health assurances are part of the public sectors and that furthermore the national and regional governments have a strong influence on the whole health sector.

Due to its public structure of the hospital sector the quality issue plays a mayor role by evaluating the performance of the participating institutions. But the definition of standards for the quality management in hospitals is never free of interests of the involved parties in the health sector. Whereas in France and Italy there exist unique nationwide quality standards for hospitals in countries like Germany or Poland hospitals apply different quality

standards. Especially in the case of Germany and Poland it turns out that different approaches for a quality management always reflect the interests of the formulating parties. As a consequence some hospitals began to work parallel with different quality standards to avoid the weak points of each existing quality standard.

This approach seems to be a blueprint for the upcoming but still lacking European quality standard in hospital management. Since all members of the EU must accept a future European quality standard for hospitals the creation of such a standard will be a political task that must regard the interests of all existing popular quality standards, i.e. it must regard the interests of all European parties within the health sector of each involved nation. This international case study shows that already the consolidation of the quality standards of Germany and Poland, two of the larger countries of the EU, will be a challenging but worth trying task because each national quality standard does not only reflect the interests of each lobbying party, it also reflects in each case a special cultural view on the whole health sector.

By comparing both quality concepts it turns out that the quality approaches of governments always reflect their political intentions and aims. So this international case study can lead to a blueprint of an upcoming EU-standard in quality management for hospitals by keeping in mind that Germany represents the largest population in the "old 15" of EU whereas Poland is the country with the largest population among the new members of the Union. The future quality standard for hospitals in the EU must therefore respect the intentions of the quality concepts of both countries.

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