Literatura

1. Written Evidence from the Health Departments for Great Britain, Review Body on Doctors' and Dentists' Remuneration Review for 2001, London, Great Britain.
2. Health In Transition, England. 1999, WHO Observatory, Kopenhagen.
3. 2001 Summary Findings, Employer Health Benefits, The Kaiser Family Foundation and Health Education and Research Trust, Los Angeles CA.
4. Cutler DM. Equality, Efficiency, *And Market Fundamentals: The Dynamics Of International Medical Care Reform*. Department of Economics, Harvard University, Cambridge, MA, and National Bureau of Economic Research, JEL Categories: H51, I11.
5. Medicare Payment Policy, Report to Congress, The Medicare Payment Advisory Commission (MedPAC), March 2002.
6. Health in Transition, Germany 2000, WHO Observatory, Kopenhagen.
7. Körver I. *A Case for the Case: Redistributing Physicians' Fees in Germany*. National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung, KBV), Cologne, Germany.
8. Health in Transition, Denmark 2001, European Observatory on Health Care Systems 2001.
9. Rodwin VG. *The Marriage of National Health Insurance and la Medecine Liberale in France: A Costly Union*, Milbank Memorial Fund Quarterly 59, no. 1 (1981): 16-43; and Rodwin VG. Management without Objectives: The French Health Policy Gamble, in The Public/Private Mix for Health, ed. G. McLachlan and A. Maynard (London: The Nuffield Provincial Hospitals Trust, 1982).
10. de Pouvourville G, Renaud M. *Hospital System Management in France and Canada: National Pluralism and Provincial Centralism*, Social Science and Medicine 20, no. 2 (1985): 153-166.
11. For a case-study comparison of an American hospital and a French hospital, see Rodwin VG et al. *A Comparison of Staffing at Coney Island and Louis Mourier Hospitals*, in Public Hospitals in New Yark and Paris, ed. V. G. Rodwin, et al. (New York: New York University Press, 1992).
12. Rodwin V, Grable H, Thiel G. *Updating the Fee Schedule for Physician Reimbursement: A Comparative Analysis of France, Germany, and Canada*, Quality Assurance and Utilization Review (February 1990): 16–24; and D. Wilsford, Doctors and the State: The Politics of Health Care in France and the United States (Durham, N. C.. and London: Duke University Press, 1991).
13. de Pouvourville G. *Hospital Reforms in France under a Socialist Government*, The Milbank Quarterly 64, no. 3 (1986): 392-413.
14. Rodwin VG. *Inequalities in Private and Public Health Systems: The United States, France, Canada, and Britain*, in Ethnicity and Health, ed. W. Van Home (Milwaukee: University of Wisconsin System American Ethnic Studies, 1989).

15. Blendon RJ, et al. *Satisfaction with Health Systems in Ten Nations*, Health Affairs (Summer 1990): 185-192.
16. Pallesen T. *Health care reform in Britain and Denmark: the politics of economic success and failure*. Aarhus: Politica; 1997.
17. Nyfigen DSI Institut for Sundhedsvasen. Meget forsigtig '90/10'– start i 2000. Nyhedsbrev for finansielle systemer inden for sundhedsvasen 2000; 11 (Forar 2000): 1-4.

Przypisy

[1] Mowa o takich świadczeniach, jak świadczenia stomatologiczne, procedury wysoko specjalistyczne, niektóre badania diagnostyczne, czy z drugiej strony świadczenia ponadstandardowe.

[2] *System rachunków zdrowia w Polsce* praca zbiorowa, red. Kawiorska D, Schneider M., Basys 2002, www.bpz.gov.pl

[3] „prawdziwa" w tym miejscu oznacza taką, za którą pacjent byłby skłonny zapłacić.

[4] Kami Troy, MPH Heller Healthcare, The Relationship Between Physicians' Workload and Patient Satisfaction, http://www.govmedcareers.com/partners/heller/news-articles.asp, Helen Mulholland, Alexander L Muir Time to Care, A Report on Consultant Physicians Workload, The Royal College of Physicians & Surgeons of Glasgow, Scotland, May to June 1996.

[5] MEDICARE SCHEDULE REVIEW BOARD, Remuneration Rates Study, EXECUTIVE SUMMARY, Healthcare Management Advisors Pty Ltd, HEALTHCARE MANAGEMENT ADVISORS, Camberra 2000

[6] AMA Center for Health Policy Research, Socioeconomic Monitoring System Core Surveys for 1995–1996

[7] CPR – *customary, prevailing and reasonable* – zwyczajowe, przeważające, rozsądne – stosowane jako zasady ustalania przez praktyki lekarskie cen do refundacji przez publicznego płatnika.

[8] W praktyce chodzi nie tylko o usługi lekarzy, ale także innych profesjonalistów medycznych, czy nawet laboratoriów.