PRACA POGLĄDOWA
REVIEW ARTICLE

ORGANIZATIONAL AND LEGAL DETERMINANTS OF IMPLEMENTING INTERNATIONAL EXPERIENCE IN THE HEALTH CARE SECTOR OF UKRAINE

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ABSTRACT

Introduction: The reform of the health care system, which is taking place in Ukraine today, is aimed at increasing the efficiency of providing timely and quality medical care.
The aim of the paper is to provide theoretical and practical study of existing models of organizing the health care system in the leading foreign countries, as well as to substantiate the possibility of implementing the most optimal of them in Ukraine.
Materials and methods: The author of the article has used the methods of analysis and synthesis, as well as comparative and legal method. In particular, the author has carried out the analysis of the experience of different countries in organizing the health care system.
Review: The author has studied international experience of legal regulation of the relations in the health care sphere, which use private, state and mixed models of the organization and financing of the health care system.
Conclusions: The author has emphasized on the necessity of using the latest achievements of the leading foreign countries in the sphere of the organization of the health care system and the establishment of additional guarantees for the financially disadvantaged groups of citizens, through the development and financing of social programs for the availability of medical care (based on the model of existing Medicare and Medicade programs in the USA); the application of marginal maximum prices for health services provided by private health care facilities (Japan); introduction of compulsory payment to the insurance fund from the income of legal entities employing hired labor (Germany), etc.

KEY WORDS: medical insurance, health care system, model of organizing the health care system, disease prevention, family medicine

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INTRODUCTION

Each state, which seeks to ensure a high living standard for its citizens, creates legal, organizational, economic and social principles for the functioning of the health care system.

Implementation of the European integration aspirations of Ukraine is impossible without the implementation of the principles existing in the Member States of the European Union (for example, the principles of full coverage of the population by health care, solidarity of financing, availability and high quality of medical care, etc.). For the implementation of these principles and in order to improve the health of the population of Ukraine, we search for an optimal model for the organization of the health care system. At the same time, health care legislation is being improved as the basis for increasing the level of providing medical care and creating conditions for maximum coverage of the population by affordable and quality medical care with minimal financial resources.

THE AIM

The objective of the paper is to provide theoretical and practical study of existing models of organizing the health care system in the leading foreign countries, as well as to substantiate the possibility of implementing the most optimal of them in Ukraine.

MATERIALS AND METHODS

The author of the article has used the methods of analysis and synthesis, as well as comparative and legal method. The analysis of the experience of different countries in organizing the health care system contributed to the definition of the issues of this publication, as well as the formulation of the author's vision of the ways to improve legal regulation of the organization of the health care system in Ukraine.

REVIEW

There are different health care systems, which depending on their organization and financing are divided into private, state

and mixed (with the use of the mechanism of obligatory and voluntary medical insurance).

In order to determine the optimal model of the organization of the health care system for Ukraine, we will analyze each of them and consider the experience of their implementation in different countries of the world.

Thus, a private model is characterized by: decentralization of financing, extensive infrastructure of insurance companies, the lack of state regulation. When applying this model, medical services are goods that can be freely bought and sold. Financing the expenses for medical care is provided by citizens and partly by legal entities – employers as deductions from their income [1, p. 111].

In accordance with the market (private) model of the organization of the health care system, such a system was developed in the United States, which was represented by independent services at three main levels: family medicine, hospital care and public health care.

Family physicians provide services through private practice or are combined with other doctors and provide outpatient and emergency care to patients in hospitals. If necessary, family physicians guide their patients to narrow specialists. The services of family physicians are paid directly by patients. Family medicine in the United States is the primary source of health care. The activities of family physicians are controlled by several independent organizations. These organizations include: the American Academy of Family Physicians (responsible for defining the policy of family practice, has a decisive voice while discussing health care issues at all levels of the executive power, acts as a representative of the interests of family physicians and controls their education); American Committee on Family Practice (responsible for official certification of family physicians); Commission on the verification of the training of interns in the field of family practice at the Accreditation Council of graduates of medical health care institutions (controls the postgraduate education of family medicine specialists) [2, p. 220].

The main sources of financing the American health system are private and non-commercial insurance, which covers about 85% of the population (about 50% of them are insured by their employers, 10% are self-insured, the rest are insured within the framework of state programs) [3, p. 29].

Private health insurance funds in the general budget of the health care system in the United States is 33%, funds from other private sources – 4%, personal funds of citizens – 21%. We note that there are more than 2,000 health insurance companies in the United States providing hospital and community health care services [1, p. 111].

State programs for supporting socially vulnerable groups play a significant role in providing medical care to the population. The most widespread among them are Medicare and Médicade [4, p. 28], which funds constitute respectively for about 10% and 17% in the general health care budget of the United States [1, p. 111].

The Medicare state program is designed to provide medical assistance to patients aged from 65 (lawfully residing in the United States for at least 5 years and paid (or their spouses) taxes on Medicare needs for at least 10 years); older persons with disabilities (who receive disability assistance for at least 24 months); patients with chronic renal insufficiency or those who need a kidney transplant; patients with amyotrophic sclerosis and those having the right to social insurance in case of disability [3, p. 29-30].

The Medicare program is targeted at financially disadvantaged groups of citizens, funded jointly by the US government and the States, and its financial fund is formed from a special income tax of legal entities – employers and employee income. The federal government pays approximately half of all program costs at the expense of the general tax; the rest is paid by the State. Each State manages its Medicaid program, but the federal Medicaid Service Center controls this program and sets requirements for services, their quality, funding, and standards. We note that this program is cost-based program for the US government [2, p. 221].

The issue of health insurance in the United States up to 2010 was considered as a private affair of every person. Everything has been changed with the implementation of the medical reform aimed at reducing expenditures on the medical sector from the budget, mandatory provision of all layers of the population by health insurance and increasing state regulation of the health care sphere [5; 6, p. 5].

Complex reforms at the US health insurance market were to provide financial assistance to financially disadvantaged and average income individuals, who purchased insurance coverage, supporting the States that enlarged insurance coverage and their Medicaid programs for the elderly people with low incomes. At the same time, they improved the mechanism of medical insurance of people who had been already insured before the reform. The result of the reform was the inclusion of the basic set of health care services (care for childbirth, treatment of mental health and health problems due to the use of narcotic substances, services for the prevention of diseases, in particular, female) into the insurance coverage [5].

As a result of the reform, the number of uninsured persons in the United States declined from 49 million in 2010 to 29 million in 2015 [5]. Up to 2017, more than 20 million people had received health insurance through federal health insurance exchanges, the growth rate of health care costs somewhat slowed down, and the quality of insurance was generally improved [7, p. 2]. However, the workload of medical employees increased with the adoption of the reform, and insurance companies were forced to increase the value of insurance packages, which included a significant number of services [8, p. 260]. Therefore, about 16% of US citizens still do not have health insurance. Hence, the US health care system, based on market principles, has no such a property as the availability of medical care for all segments of the population [8, p. 260].

We note that the President D. Trump attempted to abolish the health care reform introduced in 2010. In accordance with the Law on Reduction of Taxes and Jobs, adopted by the Congress and signed by D. Trump in 2019, the penalty for the lack of medical insurance was canceled. This may lead to the increase in the number of uninsured Americans and the growth in expenditures for health care, since uninsured people will address to urgent care rooms for primary care physicians [9].

Hence, the US government's health care system is characterized by: the availability of medical programs for financially disadvantaged citizens funded by federal, state budgets, by private individuals and employers; the prevailing financing of medical care by individuals through their contributions to health insurance funds.

However, this system also has such serious disadvantages as the high cost of medical services, which does not ensure the availability of medical care, the imperfection of the mechanisms for using financial resources, the lack of state regulation and control over the quality of medical services. Besides, the private system is characterized by free, unregulated formation of pricing for medical services and significant state expenditures for health care (for example, these costs in the United States are over 16% of gross domestic product) [1, p. 113].

Consequently, the only way to use the US experience in Ukraine is through the improvement of the legislation on programs for financing medical assistance to financially disadvantaged groups of citizens, by expanding the network of medical institutions, by increasing the level and application of the optimal mechanism of remuneration for medical employees, and by covering the expenditures for disease prevention by the state programs.

The organization of health care system based on compulsory medical insurance of citizens is applied in such states as Germany, France, Austria, Belgium, the Netherlands, Sweden and Japan. Thus, Germany's health insurance system is characterized by high standards of medical care and is considered to be one of the best in the European Union. The model of the health care system existing nowadays in Germany was founded by Otto von Bismarck and was based on the principles of social solidarity, decentralization and self-regulation.

The financing of the health care sector is mainly carried out at the expense of obligatory state health insurance funds. Medical care is available to all people, regardless of their financial situation. Every German citizen must have health insurance. There are two types of health insurance: compulsory and private. The main principle is – the higher the income, the greater the insurance payments. Nowadays about 97% of German citizens have health insurance [10].

The control over the provision of services in the amount that is guaranteed by health insurance is provided by the sickness funds, which have the powers in the field of financial management transferred by the state authorities.

All sickness funds are non-profit organizations. To cover the expenditures for medical care, they collect contributions from the members, which are levied on wages, pensions, unemployment benefits, etc. Sickness funds have the right to set a deposit rate that is necessary to cover the expenditures. The state does not interfere in the management of sickness funds, but only supervises their activities [11, p. 120].

German model of the health care system is characterized by: the presence of non-governmental insurance companies and companies with legally defined status, regulated by the state; significant increase in demand for medical care and total health care expenditures while introducing insurance policies; the emergence of new purchasers of medical services in the state – insurance companies (funds) and competition between them; the presence of obligatory contributions of employees and employers or special taxes (25-35% of state funding); conclusion of contracts with health care providers (and not with regional health care authorities) by the companies; payment of medical services by patients not covered by insurance, or part of their value (mean of reducing the demand) [1, p. 111].

The advantages of the German health care system include: compulsory health insurance and state-guaranteed level of health care for everyone; high level of medical care; sufficient amount of health care financing by the state, etc.

However, one of the problems of the German health care system of financing is the increase in the number of unemployed. This leads to the growth in the burden of insurance contributions paid by ablebodied citizens.

In regard to the introduction of insurance medicine in Ukraine, the increase in the tax burden on employers, in today's conditions of economic instability, will lead to negative economic consequences. At the same time, there is an experience in establishing sickness funds in Ukraine, but the insurance mechanism differs from that used in Germany, because insurance is voluntary and the state does not supervise them.

Ukraine has implemented the state (budget) model of financing the health care system, according to the Concept of Health Care Financing Reform, approved by the Cabinet of Ministers of Ukraine on November 30, 2016 No. 1013-p. This model involves financing the health care for all categories of people from the general tax revenues to the state budget. Therefore, we consider the financing and organization of the health care system in those states, where the state takes the main part in this process.

For example, in the United Kingdom, the availability and quality of medical care to the population is organized according to the Beveridge system principles, which was also developed in Greece, Denmark, Ireland, Canada, Norway, Sweden and other countries. Characteristic features of this model are: centralized oriented tax on health care; a significant role of the state in the distribution of medical resources; distribution of state funds between regional and central programs; availability of state standards for medical assistance; partial payment of medical services by patients that are not part of the state guarantees; availability of private insurance companies to insure individual cases of medical care; financing the medical care expenses mainly from expenditures of state or local budgets [1, p. 113].

Since 1948, the National Health Service operates in the UK, covering the entire population of the state, funded by 85-87% of taxpayers' money and providing free medical services to anyone legally resident in the country. The remaining funds come from private sources and voluntary health insurance sources [12, p. 11].

The health care budget is distributed by the government in accordance with the decisions of the Parliament through the central governing agency – the department of Health and Social Care. General practitioners work on the basis of individual contracts with family health care directorates. Applying for a general practitioner and for a specialist physician is free for a patient; and in the private sector patients pay for services they receive. Patients partially pay for some types of medical services – prescription of a recipe and preventive examination, with the exception of dental care, 80% of which is paid by a patient [1, p. 113].

A patient in the UK, like in Ukraine, has the right to freely choose a physician, the principle of "money goes with a patient" has been implemented, and thus, the salary of medical employees takes place according to the number of treated patients. If necessary, a general practitioner sends a patient to the specialists in different areas. Applying for a general practitioner is free.

Secondary medical care, including psychiatric care, is provided by hospitals. Trust hospitals are state-owned and are self-governing organizations subordinated to the Department of Health and Social Care and funded by local health care directorates [13].

Regarding the issues of the quality of providing medical care and patient rights protection there is the Action of Victims of Medical Accidents in the United Kingdom, which made the efforts to adopt the Proceedings Rules on Medical Errors that determine the special procedure for reviewing this category of cases [14, p. 109].

DISCUSSION

The medical reform was launched in Ukraine from January 1, 2018. New bills have been developed and amendments made to the current legislation. The main aspect of the reform in the health care sphere has become the normative consolidation of the relations between a physician and a patient through the conclusion of a declaration on the provision of primary health care. The legislator has tried to introduce organizational and legal ways of improving the functioning of medical employees, increasing the efficiency and development of the market for medical services, as well as guaranteeing the protection of patients' rights [15, p. 155].

Ukraine, like in the UK, creates conditions for efficient and accessible medical care for all citizens. In particular, medical assistance within state and communal health care facilities is provided to all citizens, regardless of their volume and without the previous, current or subsequent payment for the provision of such assistance. Besides, the adopted Law of Ukraine "On State Financial Guarantees of Medical Care of the Population" dated from October 19, 2017, No. 2168-VIII, stipulates that citizens receive necessary medical services and medicines of the proper quality at the expense of the State Budget of Ukraine, aimed at the implementation of the program of medical guarantees, from health care providers. However, according to Part 3 of the Art. 4 of the same Law, medical services and medicines not included in the program of medical guarantees are not payable at the expense of the State Budget of Ukraine stipulated for the implementation of the medical guarantees program.

According to the Art. 10 of the above mentioned Law there are uniform tariffs for the whole territory of Ukraine for the provision of medical services, pharmaceuticals and medical products, the size of reimbursement of medicines provided to patients under the program of medical guarantees. Payment according to the tariff is guaranteed to all providers of medical services in accordance with the contracts on medical care of the population concluded with them [16].

However, the partial payment of medical services is established with the adoption of this Law. Therefore, in addition to the indicated tariffs, we should set the marginal maximum prices for health care services provided by private health care institutions. Such tariffs, for example, are regulated at the state level in Japan, so patients do not feel the difference by addressing to a public or private health care institution [17].

Besides, we must provide additional guarantees for financially disadvantaged citizens through the development and funding of social programs for the availability of medical care, based on the model of Medicare and Medicade programs introduced in the United States, taking into account the economic situation in Ukraine. In particular, for the financing of these programs, it is necessary to establish a mandatory payment from the income of legal entities employing hired labor in the number of not less than 100 people or whose total annual income exceeds UAH 5 million (at the end of the reporting period). The indicated changes may be one of the stages of the gradual introduction of the mixed model of financing the health care system in Ukraine and further coverage of health insurance of the entire working population.

It is believed that we should provide the state programs for the prevention of diseases in Ukraine, which would include general education of the population on hygiene and health care, consultations on health issues, compulsory medical examinations and control over certain types of diseases, vaccination, etc. This will reduce the morbidity of the population and reduce the expenditures for health care, while not reducing the quality of medical assistance. An example of the positive introduction of disease prevention programs is Japan, which has become one of the countries with the highest lifetime indicators (86 years for women and 79 for men) [17].

CONCLUSIONS

On the basis of the conducted research, it has been clarified that the mixed model of organization of the health care system is gradually being introduced in Ukraine, which will allow the state to formally guarantee every citizen the right to free medical care, to introduce additional mechanisms for financing medical care to those, who fully need it, without increasing the expenses from the state budget.

In this context, the experience of Germany is useful at the present time, which proves the expediency of establishing non-governmental insurance funds (like the German sickness funds) that are purchasers of health services from state or private health care institutions, which will increase the level of competition between them, will facilitate more operational provision of medical care, and the increase in the number of private medical institutions.

Taking into account the analysis of the experience of different world countries regarding the legal regulation of the health care system, the main measures for the introduction of an optimal model of the organization of the health care system in Ukraine should be:

1) establishment of additional guarantees for financially disadvantaged citizens through the development and funding the social programs for the availability of health care, in line with the model of Medicare and Medicade;
2) application of the marginal maximum prices for health services provided by private health care institutions;

3) introduction of a mandatory payment to the insurance fund from the income of legal entities employing hired labor in an amount not less than 100 persons or whose aggregate annual income exceeds UAH 5 million with the gradual expansion of the group of contributors;
4) further coverage of the whole working population with the health insurance;
5) development of state programs for the prevention of diseases, etc.

To basic principles of the health care system, in order to ensure the right to affordable and quality medical care in Ukraine, should be the principles of providing compulsory medical care to all citizens, control by the state over the exercise of this right, protection of citizens, and the possibility of obtaining of both basic and additional health care in private medical institutions.

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