ФІНАНСИ. БАНКІВСЬКА СПРАВА

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WORLD EXPERIENCE OF FINANCIAL SUPPORT OF HEALTH CARE: LESSONS FOR UKRAINE

Abstract. *The article presents the characteristics of health insurance systems of different countries depending on the form of their financing. Based on comparisons it was proved that in practice there is no universal model of financial support of health care system, so the reform of this industry, including Ukrainian one, should be carried out taking into account a number of social, economic, political and geographical factors.*

Keywords: *health insurance; models of financial support of health care; international experience.*

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СВІТОВИЙ ДОСВІД ФІНАНСОВОГО ЗАБЕЗПЕЧЕННЯ ОХОРОНИ ЗДОРОВ'Я: УРОКИ ДЛЯ УКРАЇНИ

Анотація. *У статті наведено характеристику систем медичного страхування різних країн світу в залежності від форми їх фінансування. На основі порівнянь доведено, що на практиці не існує універсальної моделі фінансового забезпечення системи охорони здоров'я, тому реформування даної галузі, в тому числі і в Україні, слід проводити із врахуванням ряду соціально-економічних, політичних та географічних чинників.*

Ключові слова: *медичне страхування; моделі фінансового забезпечення охорони здоров'я; світовий досвід.*

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МИРОВОЙ ОПЫТ ФИНАНСОВОГО ОБЕСПЕЧЕНИЯ ЗДРАВООХРАНЕНИЯ: УРОКИ ДЛЯ УКРАИНЫ

Аннотация. *В статье приведена характеристика систем медицинского страхования разных стран мира в зависимости от формы их финансирования. На основе сравнений доказано, что на практике не существует универсальной модели финансового обеспечения системы здравоохранения, потому реформирование данной отрасли, в том числе и в Украине, следует проводить с учетом ряда социально-экономических, политических и географических факторов.*

Ключевые слова: *медицинское страхование; модели финансового обеспечения здравоохранения; мировой опыт.*

Urgency of the research. Health insurance is the main tool fro protection population from all kinds of risks to life and health. The major problem of national health insurance development is the question of financial support of insurance medicine and efficient management of financial resources of industry.

Target setting. Nowadays medical industry in Ukraine is in very poor condition that is accompanied by a lack of financial resources from the State and dissatisfaction with the quality of health services by the citizens. These and other factors create preconditions for finding solutions to a number of problems that occur in the health care system. That's why borrowing and the use of positive international experience in reformation of healthcare industry is an effective tool for Ukrainian government in case of development of healthcare financial support policy.

Actual scientific researches and issues analysis. Problematic aspects of health insurance development and health care system reformation are reflected in the works of both domestic and foreign scientists. An important contribution to the study of the problems of health insurance financial support were made by such scientists as P. Belli, P. Randol, John Kutzin, O. Koval, K. Bermutova, O. Vynohradova, V. Lehan, N. Avramenko, Yu. Voronenko etc.

However, among significant number of scientific publications the questions of analysis of foreign experience in reforming the health care system and determination of financial support model for health insurance in Ukraine are less studied.

The research objective. The purpose of the article is to study the international experience of financial support of health insurance and to provide recommendations for its use in Ukraine.

The statement of basic material. International experience of many years in the field of health insurance indicates the presence of various models of financial support of health care systems that have high efficiency and effectiveness. Today in the world there are three basic forms of health care financing: state or budgetary, budgetary and insurance and private. It should be noted that these models of financing of healthcare industry are interrelated and complement one another. They are almost not used separately in any country but only occupy a dominant position depending on the form of financing. Thus, all financial models can be attributed to a mixed type. Let's consider more detailed description of the health insurance models on the example of several countries.

The state (budgetary) form of financing based on the concept of W. Beveridge. This concept resides in the fact that medical service is available to all citizens and is funded at the cost of targeted taxation. Medical staff is paid based on the number of patients it serves. This system dominates in many developed countries and is implemented in Great Britain, Denmark, Ireland, Canada and other countries. Its advantages include common availability of medical service, government control of expenses and correct disposition of funds.

A striking example of budgetary form of health care financing is health insurance system of Great Britain with its high level of centralization of management. The system of National Healthcare Service is based on state financing. The main source of health care budget replenishment is taxes and tax payments (90%) and only 7.5% of budget revenues are employers' contributions. Medical institutions are owned by the Government but have the status of hospital trusts – self-managing organizations. The public health system provides preventative, primary care, hospital treatment. General Great Britain government expenses on health care are 8% of GDP. British model of health insurance has the high level of centralization, domination of budgetary financing system, as well as payment to patients of 10% of their treatment cost [1]. Attraction to health care of extra budgetary resources is the country's acute problem. It can be funds of companies whose employees can get additional medical care from medical institutions on contractual basis. The basis for healthcare industry reform of the country is decentralization of management which aims to improve and intensify the work of structural units by transferring them on a commercial basis.

As for Canada, most scientists believe this country has free health care system. 30% of total budgets of provinces is spend at its needs. Canadian model of health care systems bases on the principles of service availability, universality, mobility and inclusivity.

Since 1971 the universal health insurance system, which includes payment of all types of inpatient and outpatient treatment except dentistry, prosthetics and purchase of medicines, was introduced in Canada. Medical insurance is funded by means of general taxation, insurance contributions and payments in cash. System of medical saving accounts, which are formed from employers' contributions, functions successfully in Canada. The funds on the account are the property of the employee. The existence of saving accounts stimulates effective functioning of the healthcare industry and creates a competitive environment in the market of medical services of Canada.

Budgetary and insurance form of financing of health care system is based on a model of building social insurance system by O. Bismarck. According to this system, medical industry is financed by means of mandatory contributions from employers and employees to special funds created on profes-

sional or area basis. The amount of contribution depends on the paying capacity of the insurer, access to services depends on the needs of the insured. In most cases medical funds are independent of the Government, although they act in its legal framework. Representatives of the insured manage these funds. This system gets widespread use in Germany, Italy, Sweden, France and Japan.

Germany stands among the first countries where health insurance was introduced. Since 2009 health insurance is compulsory for all citizens of Germany. Obligatory health insurance covers 90% of the population of Germany. Total expenses on health care are highest among European countries and make 12% of GDP [2]. Insurance contributions are divided between employer and employee in proportion and at an average make 15% of salary. Contributions are accumulated in the National Fund of Social Insurance, which provides the redistribution of financial resources between health insurance participants. The funds are divided between the funds according to the scheme of equalization of health risks, taking into account gender, age and disability of the insured. The last, whose annual income exceeds 48,000 euro's, can independently choose the type of health insurance. German health insurance system solves its financial problems autonomously and independently from the State Treasury. In health insurance there are eight types of health insurance funds, which were formed on the base of historical distinction by certain regional and production criteria. The range of offered medical services depends on the capabilities of insurance, though it must ensure all medical services in case of illness of the insured. The minimum insurance package includes outpatient treatment and patient's stay in a hospital. As autonomous organizations, the insurance funds of Germany have the right to set premium rates above the basic level and also to increase the range of medical services above the basic insurance program. The insurance funds are the structural element of the country's health care system and work closely with the Government in the field of settlement payments with medical and preventive treatment facilities and share the responsibility for the healthcare industry in the country.

Unlike Germany, France has centralized form of compulsory health insurance, which was introduced in 2000. Compulsory health insurance covers 80% of the population and provides access to a wide range of services. Types of medical services are determined by the National Union of Health Insurance Funds in accordance with the recommendations of the Department of Health. Total expenses of the French government on financing the healthcare industry are 12% of GDP, moreover part of Government expenses is gradually increasing and makes 85% [3]. In France health insurance programs are financed by means of contributions for social insurance of employers and employees. Contribution rate is set centrally. Distribution of contributions among the employer and the insured is carried out in the ratio of 1:3. Social insurance contributions are accumulated in the Treasury and distributed among funds and programs of health insurance. National Fund (Employee Insurance Fund) which is under control of Ministry of Social Service and Labor is in charge of the system of health insurance funds. Its main functions are the following: determination of the amount of benefits and contributions, general control on the functioning of health insurance funds, control on the quality and cost of medical care. The National Fund has local offices, each of which is responsible for insurance in a separate area and does not compete with others. In these local offices insurance is carried out according to the territorial principle. Customers almost have no right to choose the insurance company. The Government provides low cost remedies [2]. French public health insurance funds buy medical services in public and private commercial medical and preventive treatment facilities. Health care institutions are financed by means of single national tariff system based on clinical and statistical groups.

In addition to compulsory state insurance in France there is a net of voluntary medical insurance and local funds of social assistance. Uninsured people, whose number in this country is not more than 2%, receive medical service at the expense of financial resources of social assistance funds. A large number of French employers include to social insurance package voluntary health insurance. Firstly, it increases the social status of employers, and secondly, it gives the possibility for employees to use the services of hospitals with high quality medical care and solve problems with payments for medical service (within 25% of the total cost of treatment).

Private model of health care system financing is based on the implementation of paid medical services and the existence of voluntary health insurance. The population, which is the subject to insurance, pays the premium to the insurer and the amount of premium is determined based on the average cost of services provided by the insurer. The insured, which can be put at risk, pay accordingly large amount of contribution. Patients pay the cost of medical services according to established tariffs. Such system functions in the US, the Netherlands and South Korea.

This model is characterized by financing the healthcare industry by means of financial resources of voluntary health insurance and the provision of paid medical services. In other words, there is a parallel between the private and noncommercial form of health insurance. Herewith noncommercial insurance goes on within certain government programs for specific population groups. Typically, these programs are financed from the state budget and are characterized by a limited number of insurance cases.

American health insurance system is based on a combination of financial resources of the central insurance fund and local private insurance organizations. Cash resources are accumulated in a central fund that does not perform administrative functions, and then are redistributed among insurance organizations on base of payment forms approved by the US government.

US health care system is presented by three-level structure, which is formed by independent service:

- first level - family medicine;
- second level - hospital care;
- third level - public health.

In the United States medical services are delivered by private individuals and law firms. Various commercial, charitable and government agencies offer patients both inpatient and outpatient medical services.

According to the latest estimates in the United States they spend for medical care about 16% of GDP. It is expected that the share of GDP allocated for health care in the US will be increasing and become 19.5% till 2017. In the last 30 years we have seen a real increase of expenditure on public health at the expense of government programs that could seriously undermine the financial stability of the country [4]. In most cases (59.7%) the employer provides Americans with health insurance. Employers offer two types of health insurance: fee-for-service insurance (compensation insurance) and managed service insurance.

In compensation insurance the employer pays to insurance company a premium for each employee with appropriate insurance policy. After the insured event happened the insurer pays the receipts presented by medical institution or doctor in charge. In most cases, the insurance company covers 80% of treatment expenses and the patient pays the remaining money on their own [5].

Managed services insurance provides the following: insurance company concludes contracts with doctors and hospitals to provide all kinds of medical services specified by this type of health insurance. A fixed amount of money is previously paid for the each insured on hospital's account. Outpatient treatment is often referred to this type of insurance. In case of managed services insurance doctors get fixed amount of money for the each insured, regardless of whether the patient will get extra services or not.

The government encourages and supports employers in providing their employees with health insurance and does not impose taxes on spent costs. The total amount of such tax subsidies can reach up to 150 billion dollars a year.

Many Americans, who don't have personal insurance, undergo such government programs as Medicare and Medicaid, and also other programs of the various states and local authorities for needy population. These systems cover more than 20% of the population.

Medicare - the most famous national insurance program for people over 65 years old, introduced in the 1967. Program includes inpatient care, diagnostics, medical services at home and short stay in homes for elderly people. Medicare is financed by means of a special tax on workers, part of which

they pay themselves and second part is paid by the employer. The contribution is about 15% of the income of employed Americans.

State Medicaid program was introduced in 1966 and focused mainly on implementation of insurance for people from poor families. This program is also available for the disabled, pregnant women and children. Medicaid offers a wide range of medical services: inpatient and outpatient treatment, consultations, stay in homes for elderly people, laboratory and radiological examinations. Financing of the program is carried out both by the federal government and governing bodies of states. The federal government reimburses the costs of Medicaid program by means of revenue from total tax (about 50% of total costs), and the difference is paid by the government of each state [4].

Being the most expensive in the world, the American health care system still has some problems. Many US residents can not receive adequate medical care, the sickness rate is not reduced and preventive measures often do not bring the expected result [5]. Currently there are heated debates about the availability, effectiveness and quality of health services. But the US government is constantly taking steps to improve the efficiency of the health care system and the health of population in general.

The health insurance system of South Korea is mainly financed by means of insurance contributions, personal patients' payments and government subsidies. Medical services in South Korea represented mainly by the private sector, which covers about 90% of hospital beds. All citizens of the country receive medical care on the basis of health insurance system and insurance in case of illness. Practical problems in the insurance industry are solved by the National Health Insurance Corporation, the budget of which is formed by monthly financial contributions of citizens of the Republic of Korea. National health insurance covers most of the population. Those who work must pay to the health insurance fund about 5% of salary and half of the amount the employer is obliged to deduct [1]. Contribution to the health insurance fund for private entrepreneurs is calculated based on their income, property and age. The government partially or fully pays health insurance only for the poor and those who belong to the privileged categories of citizens. In Korea there is a right for close relatives, if they are not officially employed, to use insurance of employed family member.

The level of health care spending in South Korea is quite low (7% of GDP), although there is a tendency to its constant growth. In 2015 contributions for compulsory health insurance are about 6% of salary [1]. According to this index among countries of Organization for Economic Co-operation and Development Korea occupies next-to-last place.

Conclusions. Having considered the health insurance systems of different countries it is obvious that each country has its special kind of insurance and in practice there is no single correct, universal insurance model that would fit all countries. Despite the various financing sources listed above health care systems of foreign countries practicing common tasks: high effectiveness of health care, improvement of the service quality and its availability for a wide range of people. Therefore, we should start the reform of healthcare industry in Ukraine with a study of the main advantages and disadvantages of existing models of international health insurance systems. Based on the positive experience of healthcare reform in several countries, Ukraine needs to develop its own program of insurance medicine system, taking into account current economic conditions. International experience in reforming the health insurance system shows that the financing mechanism for health care can be successfully improved both within the budgetary financing and social health insurance. During reformation of the healthcare industry the Ukrainian government should bring additional financial resources that are the funds accumulated by means of providing paid medical services, revenue from charities and voluntary health insurance. Speaking of the future, in our opinion, the ideal model for Ukraine could be the budgetary and insurance medicine, which will lead not only to the growth of a strong and healthy nation, but also contribute to the sustainable development of a market economy. To increase the efficiency of the health care system in Ukraine it is extremely necessary to implement reforms that would cover the management of this system, its financing and providing health services.

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