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MODELS OF FINANCING AND ORGANIZATION OF THE HEALTH CARE SYSTEM: FOREIGN PRACTICE

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Abstract. *This paper investigates the general principles of models of financing and organization of the health care system in the coordinates of globalization changes and European integration. The authors systematize the instrumental base for modelling the financial mechanism which ensures state guarantees in the area of medical care. The authors research in detail the features of the three main models of health care at the global level, classify the health systems of leading countries according to three main models, systematize in tabular form the practice of six countries - Israel, Sweden, France, USA, UK, Germany, in which the above models received the brightest embodiment. Authors propose the main directions of organizational principles of improving public administration of the health care financial system in Ukraine.*

Keywords: *financial system, health care, health insurance funds*, *models of organization, medical services market.*

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Introduction

In any country, the choice of the optimal health care model has the fundamental importance to ensure more efficient use of resources and improve the quality and availability of health care. The world has accumulated significant experience in the area of building and optimizing models of financing and organization of health care. Thus, the leading countries are consistently striving to expand the coverage of the population with free medical care, rationalize sources of financing and methods of allocating funds, methods of managing the health care system in order to increase its efficiency and eliminate duplication of costs [1].

Despite the fact that none of the existing healthcare models in the world can claim to be universal, the analysis of the parameters of these models, their strengths and weaknesses, as well as generalization of the experience of specific countries is important in reforming and optimizing the current healthcare model in Ukraine.

Literary review

The work of many foreign and domestic scientists and specialists is devoted to the study of problems associated with the financial and economic mechanisms which ensure state guarantees in the area of medical cares. A wide range of issues related to research in the area of medical services market and financial system of health care. For example, Karpenko and Zhylinska (2019) research the human development in the context of provision of the social safety of society. Golovanova and Krasnov (2015) present actual problems of medical insurance development during the period of market reform. Thomson and Jun (2018) explore International Profiles of Health Care Systems, etc.

Results

The aim of the paper is to study the general principles of models of financing and organization of the health care system in the coordinates of globalization changes and European integration; analysis and characterization the financial mechanism which ensures state guarantees in the area of medical care; systematization in tabular form the practice of six countries − Israel, Sweden, France, USA, UK, Germany, in which the above models received the brightest embodiment. In the article authors propose the main directions of organizational principles of improving public administration of the health care financial system in Ukraine.

A comprehensive analysis of health care systems financed from universal health insurance funds can serve as a good basis for the development of mechanisms for transferring health care in Ukraine to insurance principles, guaranteeing in practice the patient's freedom of choice of an insurance and medical organization, improving the efficiency of health care management, strengthening financial control by insurance companies over medical institutions [2].

It seems expedient to start the research by studying the *features of the three basic healthcare models.* In modern conditions, all health care models can be roughly divided into three types: budgetary (state), insurance (social insurance), private (non-state, or market).

The characteristic feature of the first model, which is known as the Semashko-Beveridge model, is the significant role of the state. Tax revenue is the main source

of funding. Medical services for the entire population are provided free of charge. The share of total expenditures from public sources in GDP is usually 8–11%. Private insurance and copayments play a complementary role. The main funding channel is the state budge [3].

The second model, known as the Bismarck model, is often referred to as a regulated health insurance system. It is based on the principles of the mixed economy, combining the medical services market with a developed system of government regulation and social guarantees. Compulsory health insurance programs cover the entire or almost the entire population with the state's complicity in financing insurance funds. As in the budget model, the state covers more than 70% of the costs of medical services, but the total government spending on health care, as a rule, is slightly higher than in the budget model, already amounting to 9–13% of GDP. Private non-profit or commercial insurance funds or companies play a decisive role in the allocation of funds, the role of the market in meeting the needs of the population for medical services is high, and patients have significant freedom in choosing insurance companies and service providers [3].

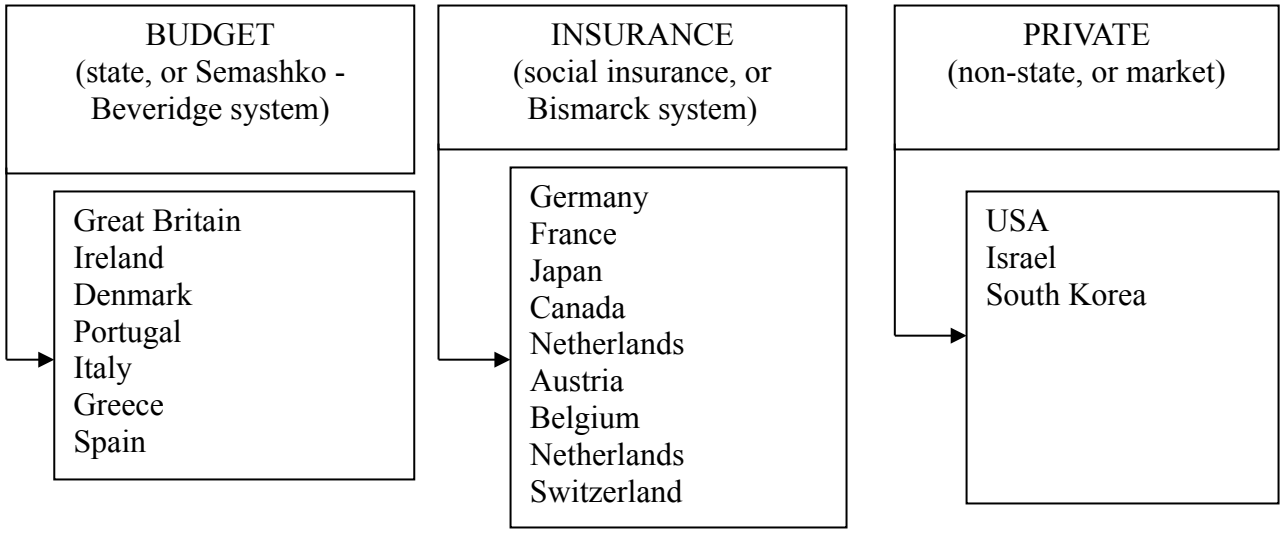

Fig. 1. Classification of health systems of leading countries according to three basic models

The private health care model is characterized by the provision of medical services mainly on a paid basis, at the expense of private insurance and personal funds of citizens. There is no unified system of state health insurance. The market plays the key role in meeting the needs for medical services. The state assumes only

those obligations that are not satisfied by the market, that is, it covers medical care for socially vulnerable categories of citizens - the unemployed, the poor and pensioners.

The Fig. 1 shows the classification of health systems in leading countries in accordance with three main models - budgetary, insurance and private. Let's explore the experience of Germany. Germany is the classic example of a social insurance model. Funding sources are distributed as follows: social health insurance - 60%, private health insurance - 10%, state budget - 15% and personal funds of citizens - 15% [4].

Table 1. Systematization the foreign experience of financial support of medical care state guarantees

Israel	The country's health care is based on compulsory health insurance. About 5% of the population is uninsured. At the same time, there is financing of about half of medical expenses by consumers - about a third - personal payments and 18% - through insurance contributions to insurance funds due to illness. For certain types of services there is commercial insurance by private insurance companies
Sweden	Medicine in Sweden is free for the population. It is financed by state and municipal funds and insignificant contributions from citizens. Sources of funding: taxes, state social insurance system and private funds. When a citizen pays 110 euro, medical care is provided free of charge. Absolutely free medical care is provided to children and pregnant women
France	Compulsory health insurance system prevails. Collective agreements cover the rest. Employers pay a tax of 12.8% of salary for each employee, 0.75% is paid by the employee
USA	Funding for health care is provided by private insurance. The federal government guarantees health insurance for the elderly and the poorest. 46% of the funding is provided by the federal and state governments. Employers pay 27% of benefits. The other 27% are from private individuals. More than 15% of Americans are uninsured
United Kingdom	Health care budgeting system. 90% of the budget consists of taxes. 7.5% - employer contributions. Patients pay 10% of the cost of treatment. All funds are collected in the central budget and distributed from top to bottom along the management vertical. Deficits in the health care area are partially offset by private insurance and an increase in paid health care.
Germany	The basic principle is that the government is not responsible for financing health care. There is a decentralized health insurance system. Medicine is financed from 3 sources: insurance premiums of entrepreneurs - tax deductions; earnings of employees - deductions from wages; funds from the state budget

Known as sickness funds (Krankenkassen, German), organizations and associations of sickness funds form the backbone of the Social Health Insurance (SHI) system. They establish self-regulatory structures that manage funding and service delivery to the extent guaranteed by compulsory health insurance law. The

health insurance funds have the status of private non-profit organizations; they are engaged in insurance of risks associated with illness [5].

In the Table 1 there is systematization the foreign experience of financial support of medical care state guarantees.

Conclusions

Thus, the analysis of foreign experience allows us to draw the following conclusions:

1. There are no specific models in their pure form in any country.

2. No model is versatile.

3. In any of the models, there is only one dominant source of funding.

4. In the budgetary and insurance models, the state provides more than 70% of all expenses.

5. The most important factor in the sustainability of systems is the coverage of the population with free medical services, the absence of duplication of costs, the efficiency of resource use and the availability of medical services.

6. No country can meet all health needs from public funds without private insurance and / or co-payments.

The problem of functioning of the financial mechanism of providing state guarantees of medical care in Ukraine is as follows: the structure of providing state guarantees in different areas is uneven. Deficiencies in the financial provision of state guarantees lead to an outflow of staff from hospitals, reducing the quality of medical care. The proposed ways to improve the financial mechanism of state guarantees of medical care by improving the organizational framework are that it is necessary to clearly define those medical services that should be fully guaranteed by the State. It makes sense to add to the available sources of financing of medical services additional sources, namely - health insurance, financing of medical services for their employees by type of "corporate client", expanding the range of services that can be considered paid. Improving efficiency is also the key for improving the results of the reform and creating opportunities to support priority actions, in particular through the restructuring of hospitals.

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