THE WAY THE HEALTH CARE SYSTEM IN UKRAINE LOOKS LIKE: INTERNATIONAL PRACTICES WITHIN NATIONAL REALITIES

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ABSTRACT
Introduction: Nowadays there is the transformation of the national health care system in Ukraine, the ultimate goal of which is to create a modern, competitive model of medical care of citizens on the basis of forming packages of free medical services. However, the model adopted by Ukraine is in contradiction with national legislation in part of free medical aid guaranteed by the Art. 49 of the Constitution of Ukraine, and fragmentary considers positive international practices.

The aim of the paper is to determine the mistakes of the reform of the Ukrainian health care system and to reveal the positive international practices of the organization of health care systems that can be implemented in Ukraine.

Materials and methods: National and international legislation, official web resources of the executive authorities of Ukraine, statistics of the World Health Organization, materials of journalistic and scientific periodicals are the materials for the research of the health care system in Ukraine in comparison with international practices. Research methods are cross-sectoral, complex statistical, comparative, generalization, analysis and synthesis. In order to obtain the results, the authors have conducted a critical analysis of the current norms of the national Ukrainian legislation in the health care sector.

Review: The authors of the article have studied the main disadvantages of the national health care system in accordance with the concept of reforming the medical sector. Positive international practices that can be implemented into Ukrainian system for the real improvement of medical human rights in Ukraine have been revealed.

Conclusions: It has been proved that the ongoing reform of the health care system in Ukraine needs to be reviewed and optimized. It has been offered to consolidate a perspective model of the Ukrainian health care system, its principles and guarantees of immunity at the legislative level.

KEY WORDS: health care system, the right to health care, reforming, health care principles, implementation, guarantees of immunity
in Ukraine contradicts to the national legislation in part of free of charge medical aid guaranteed by the Art. 49 of the Constitution of Ukraine.

An efficiently organized health care system should ensure the realization of medical rights by citizens in Ukraine, as well as contribute to strengthening the economic potential of the state due to the population’s ability to work. Consequently, the current state of the health care reform in Ukraine is characterized by inconsistency and miscalculations, when the forecasts, perspectives and expected results are perceived as real achievements. In order to minimize the negative consequences of such strategic mistakes, it is necessary to consolidate the perspective model of the health care system of Ukraine at the legislative level, to establish its principles and guarantees of inviolability.

THE AIM
The objective of the paper is to determine the shortcomings of the reform of the Ukrainian health care system and to reveal the positive foreign practices of health care organization that can be implemented in Ukraine.

The purpose of the article is to study the perspectives of Ukraine’s adoption of positive international practices on the organization of health care systems to improve the legislation in the medical sphere and to clarify the vectors for reforming the health care system in Ukraine.

MATERIALS AND METHODS
The materials of the research are the provisions of national and international legislation, official web resources of the executive authorities of Ukraine, statistics of the World Health Organization (hereinafter – WHO), materials of journalistic and scientific periodicals, systematized approaches of supporters and opponents of the reform. The lack of a dominant point of view regarding the reform of the health care system in the Ukrainian society has been established. The methods of the presented research are cross-sectoral, complex statistical, comparative, analysis and synthesis. In order to obtain the results the authors have conducted the analysis of the norms of administrative and medical legislation. Analysis and synthesis allowed to consider the reform of the medical sphere as a complex phenomenon. With the help of the legal analysis method, the legislative provision for ongoing medical reform has been defined. The statistical method has allowed to determine the level of efficiency of the health care system in Ukraine. Comparative and legal method has allowed to reveal the shortcomings of the national legislation within the prism of the studied problem and to develop propositions for their elimination.

REVIEW
Article 1 of the Law of Ukraine “On the Basis of the Legislation of Ukraine on Health Care” dated 19 November 1992 No 2801-XII stipulates that the legislation of Ukraine on health care is based on the Constitution of Ukraine and consists of these Fundamentals and other legislative acts adopted in accordance with them, regulating public relations in the field of health care [3].

The Article 1 of the Law of Ukraine “On the Basis of the Legislation of Ukraine on Health Care” dated from November 19, 1992 No. 2801-XII stipulates that the legislation of Ukraine on the health care is based on the Constitution of Ukraine and consists of these Fundamentals and other legislative acts adopted in accordance with them, regulating public relations in the field of health care [3].

At the same time, the Laws of Ukraine “On Increasing the Availability and Quality of Medical Care in Rural Areas” dated from November 14, 2017 No. 2206-VIII, “On State Financial Guarantees of Medical Care of the Population” dated from October 19, 2017 No. 2168-VIII; Resolution of the Cabinet of Ministers of Ukraine “On Approval of the Methodology for Calculation of the Costs of the Medical Services” dated from December 27, 2017 No. 1075, “On the Establishment of the National Health Service of Ukraine” dated from December 27, 2017 No. 1101, “On Approval of the Procedure for the Implementation of State Guarantees for Medical Care of the Population for the Program of Medical Guarantees for Initial Medical Care for 2018” dated from April 25, 2018 No. 407; Decrees of the Cabinet of Ministers of Ukraine “On Approval of the Concept of Health Care Financing Reform” dated from November 30, 2016 No. 1013-r, “On Approval of the Plan of Measures for the Implementation of the Concept of Health Care Financing Reform for the Period up to 2020” dated from November 15, 2017 No. 821-r. do not comply with the Constitution of Ukraine and the Fundamentals of Ukrainian Health Care Legislation as the Basic Law. Their discrepancy is related, first of all, with the constitutionally guaranteed right to health care, medical care and medical insurance in the aspect of free-of-charge basis for the realization of this right (except for insurance, which is not obligatory).

Numerous problems that accompany the reform remain unresolved even with the adoption of the legal base adopted in support of medical reform in accordance with the medical legislation of Ukraine. Thus, purchase of medicines through international institutions, transparency of reimbursement schemes for medical products, availability of medical care in rural areas, and the protection of personal data of patients in information bases are under the question for reasoning their effectiveness.

Miscalculations in the implementation of medical reform in Ukraine, as well as positive international experience that can contribute to their elimination will be discussed below.

DISCUSSION
The imperfection of evaluating the effectiveness of the ongoing medical reform in Ukraine is confirmed by the statistics (Health Care Index for Country) from Numbeo. Suggested analysis system is based on the opinion of re-
spondents regarding health care system satisfaction rather than on official statistical materials and is presented in dynamics, depending on the year and place of the state in the ranking: 2018 – 65; 2017 – 74; 2016 – 63; 2015 – 95; 2014 – 75; 2013 – 71; 2012 – 65 [1]. There are fluctuations up to 10 points during a simple analysis both before and after the introduction of medical reform in Ukraine. In general, Ukraine’s indicators for the whole reporting period are approaching the lower bound of the ranking, and thus, are unsatisfactory and convincingly testify about ineffectiveness of the system in the whole and the absence of obvious changes for the better.

Regarding the reform itself, the introductory part of the Ordinance of the Cabinet of Ministers of Ukraine “On Approval of the Concept of Health Care’s Financing Reform” dated from November 30, 2016 No. 1013-r states that international experience, recommendations of the World Health Organization, as well as research of the specifics of the current model of the health care system of Ukraine indicate that the only way to provide high-quality medical care without financial stress for citizens is to move to financing medicine according to the insurance principle [4]. The approved Concept also stipulates that we offer to implement the model of state joint medical insurance in Ukraine that will take into account the best modern practices and experience of the transformation of health care systems in the world, in particular in Central and Eastern Europe [4]. However, there is a question: whether we can consider the health care model as insurance one and whether it corresponds to advanced international practices. Nowadays, we created an agency that manages health care budget. However, the state medical fund was not created. Therefore, the concentration of financial levers in the National Health Service of Ukraine (hereinafter – NHSU) will only contribute to corruption risks, where the system of public authority in Ukraine suffers from these risks.

Supporting the reform, the Ministry of Health of Ukraine (hereinafter – MHU) observes that various types of payment for medical services are fixed by the Law, which allows the National Health Service of Ukraine to make payments for the full or partial payment of medical services. The MHU emphasizes that the National Health Services of Norway, Canada, Italy and Spain pay for similar models [5]. This position of the MHU is controversial, since each of the above-mentioned states has its own peculiarities in the organization of the health care system, which are united only by the presence of a specially authorized medical agency (agencies) responsible for medical services.

O.V. Bohomolets emphasizes that the MHU has not determined the model of health insurance in Ukraine. Earlier Ukraine’s acting Minister of Health, Uliana Suprun in her interview to BBC Ukraine, noted: “We are introducing something more like the British system, where every citizen of Britain has state insurance. They do not have to record anywhere, look for some kind of insurance; it just works automatically with each visit to a physician or a call for ambulance” [6]. However, citizens in Ukraine do not have a conditional “account”, which holds funds set aside for treatment. Instead, health expenditures are distributed among institutions, where patients have applied, and the range of medical services that may be received for free or partly depends on the volume of services provided. It deprives a patient of the choice, because while choosing between institutions or specialists, he is not able to choose a more expensive / cheaper drug or hemanalysis, because the state has already decided on this matter.

We should agree with the opinion of V.M. Pashkov that the introduction of state health insurance in Ukraine does not contradict the constitutional prescription for the free of charge medical care within state and communal health care institutions only if the payers of compulsory insurance payments (contributions) are business entities, state funds, etc. The collection of such payments (contributions) from citizens in the system of state health insurance will not be in line with the constitutional provision, as it will be one of the forms of payment for providing them assistance in state and communal health care institutions [7].

However, it should be noted that, first, the Constitution of Ukraine should determine the obligatory nature of state health insurance, its scope and conditions of solidarity. Secondly, the Law of Ukraine “On State Financial Guarantees of Medical Care of the Population” dated from October 19, 2017 No. 2168-VIII should be amended in part of specification of the mechanism of state compulsory health insurance and its components. Thirdly, the Law of Ukraine “On the Basis of the Legislation of Ukraine on Health Care” dated from November 19, 1992 No. 2801-XII, needs to be supplemented with the provisions that take into account the Twelve Principles of the Organization of Health Care for any national health care system, adopted by the 17th World Medical Assembly (New York, USA, October 1963, with edits of the 35th World Medical Assembly, Venice, Italy, October 1983) [8]. None of these principles has been fully taken into account in the Ukrainian health system at the present time.

We believe that the preliminary creation of the legal basis with the consolidation of the latter at the legislative level will minimize speculation in determining the optimal model of health care and make it impossible that regulatory acts, adopted in support of the reform during the transformation of the national health care system in Ukraine, do not comply with the Constitution of Ukraine. At the same time, the guarantees of inviolability of the health care system chosen by Ukraine will be the legislative consolidation of the said propositions.

In order to reform the medical system in Ukraine, it is expedient to borrow the experience of the states that were part of the USSR, and now, thanks to successful reforms integrated into the European Union (hereinafter – the EU) as the actual participants. The experience of such countries is extremely useful in view of the identity of their former health care systems with Ukrainian one. Instead, attempts to imprint leaders in health care ratings on the matters of medical rights of citizens are possible only through
individual programs or directions, since the difference in organizational, financial and legal components of health care systems is too great.

The Member States of the Organization for Economic Cooperation and Development (hereinafter – OECD) spend on the average 9% of the gross domestic product (hereinafter – GDP) on the health care sector. According to 2017 data, the United States of America (17.2%), Switzerland (12.4%) and Germany (11.3%) ranked the leader on this indicator. Turkey (4.3%) had the lowest health expenditure indicator in relation to GDP (9.3%). For comparison, about 3.7% of GDP is planned in Ukraine in 2019, which is well below the UN recommended minimum level of 5%. Some politicians emphasized on this inconsistency during the meetings of Verkhovna Rada of Ukraine, but traditionally, the health care sphere remained aside from full financing.

Here is a summary of the consolidated budget expenditures for health care in 2016-2019 (see Figure 1) [10]. However, the further reform of the health care system, which mitigates the increase in the quantitative indicators of financial support of the sector, should be provided by the budget funds. Consequently, the desire and perspectives in the medical sphere differ significantly from the real situation.

Let's consider the experience of medical reforms of the former USSR countries that have successfully integrated into the EU.

Latvia. Since 1990, the state has tried both the system of social health insurance (SHI) and the system of National Health Service (NHS) without an alternative possibility of returning to the Soviet system of health care. Uldis Mitenbergsa, Girts Brigis a, Wilm Quentinb in the work «Healthcare financing reform in Latvia: Switching from social health insurance to NHS and back?» note that governments that plan to implement state health insurance do this mainly on the basis of arguments that it will improve the ability to raise health revenues by making health care funding more predictable (irrespective of political interference) and that people will be more willing to contribute their percentage if the right to health care is related to such contributions. However, it is obvious that part of the health care budget can be increased regardless whether health care taxes are paid or not and that the combination of the right to health care and payment of contributions will create access problems for uninsured persons. Governments contemplating the introduction of SHI mostly do so based on arguments that it would improve the ability of raising revenues for health, making healthcare financing more predictable (independent of political interference), and that people would be more willing to contribute if eligibility for healthcare services is linked to making contributions. However, it is clear that the healthcare budget could also be increased independently of whether income taxes earmarked for health or not, and that linking healthcare entitlement to the payment of contributions will create access problems for the uninsured [11]. However, the binding of each citizen to the personal account of the state health insurance fund will facilitate the withdrawal of part of the population from the shadow sector of wages.

According to the information from the booklet “State of Health in the EU. Latvia. Country Health Profile 2017”, a part of the population of Latvia is dissatisfied with the level of health care provided by the state, although Latvia has the state health care system, the completeness of which is somewhat smaller than in other EU states. As a result, a large proportion of people report about the problems in obtaining assistance mainly because of financial barriers, as well as due to geographic reasons or long terms of waiting for medical care.

Latvia has universal health coverage, although the breadth and depth of coverage is more limited than in most other EU countries. As a result, a large share of people reports problems in obtaining care mainly because of financial barriers, but also because of geographic reasons or long waiting times [12].

Both health care systems have positive and negative aspects. It should be noted that Ukraine has been preparing for the introduction of compulsory state health insurance for a long time, and as a result, the Ministry of Health of Ukraine lobbies borrowing the system of state guarantees for the provision of a complex of medical services (NHS), the volume of which depends on budgetary infusions and the political situation, but not from the participation of each particular citizen in his own health care.

Lithuania. After the restoration of independence in 1989, Lithuania inherited a centralized system that mainly provided ineffective health care management and resources allocation. To correct the situation, restructuring and decentralization were identified as strategies that would enhance the effectiveness of providing health services. Decentralization of the health care system was achieved by segregation of primary health care (family doctors), secondary medical care (specialized physicians) and medical care of the highest level (university clinics of the highest specialization). The development and reform of the primary health care system were considered as the key factor in the reform of the health care system, however experience of other countries demonstrates that decentralization in practice does not necessarily increase the efficiency.

After the restoration of its independence in 1989, Lithuania inherited a centralized system that mainly delivered inefficient health care management and resource allocation. It opted for restructuring and decentralization as strategies that would to increase the efficiency of our health services. Decentralization of the health care system was achieved by segregating primary health care (family physicians), secondary health care (physicians – specialists), and tertiary health care levels (high specialization university clinics). The development and reform of primary health care was seen as a key factor in the entire health care reform. However, the experience of other countries shows that in practice, decentralization does not necessarily enhance efficiency [13]. At the same time, the maximum effectiveness of the health care system is not achieved in those countries that are most successful within economic
potential, but where there is no significant difference between the richest and the poorest (strong middle class). Accordingly, the emphasis on socially vulnerable segments of the population, the balance between decentralization and centralization, between the state and private sectors in the health care sphere, improving governance, and assessing such changes should contribute to solving many medical problems, not only in terms of social ethics, but also in terms of justice [13].

There is a single contractor of medical services in Lithuania – it is the National Health Insurance Fund (NHIF), which is funded by mandatory income contributions and the central government for the unemployed population. The health insurance system in Lithuania has an effective preventive (anticyclical) mechanism and successfully protects state health expenditures during financial crises. At the same time, Lithuania has one of the highest mortality rates in the EU, indicating that the health care system should improve its effectiveness. Quality indicators provide an ambiguous picture, but both hospitals, and primary health care services improve their activities. Lithuania’s exceptionally high level of suicide is noticeable, despite the efforts to reform the mental health system. Improvement of inpatient care and the improvement of the primary level of providing medical services are ongoing.

The NHIF, the single purchaser of personal health services, is funded by compulsory income-related contributions and the central government for the non-working population. The Lithuanian health insurance system has an effective counter-cyclical mechanism in place and was successful in protecting public spending on health at the time of the financial crises. Lithuania has among the highest amenable mortality rates in the EU, indicating that the health care system can improve its effectiveness considerably. Quality indicators provide a mixed picture, but both hospital and primary care services are improving their performance. Lithuania’s exceptionally high suicide rate is notable, despite mental health reform efforts. Reforms are ongoing to cluster acute care in centres with larger catchment areas, create networks of hospitals to provide each service in a more limited number of locations and implement volume thresholds to increase both efficiency and quality. The progress in primary care is following several years of reform, with modernised general practitioner and nursing services and a comprehensive reimbursement system incentivising prevention [14].

Ukraine also makes an attempt to strengthen the primary level of providing medical care, but preventive mechanisms for guaranteeing the inviolability of the package of medical services during the period of economic crises, as well as the availability of medical services for the rural population or socially vulnerable groups have not been created.

Estonia. The Estonian Health Insurance Fund (EHIF), founded in 2001, is the sole payer on the market of providing compulsory health insurance. It is the public state institution that operates in accordance with the Estonian law. EHIF, founded in 2001, is a single payer on the market who organises the mandatory social health insurance in Estonia. It is an independent public entity that owns its assets. The Fund has covered more than 95% of the population of Estonia. Estonia’s health insurance system is based on solidarity. About 49% of the insured persons are those who do not take part in the fund’s filling, including children, students, retired people with disabilities and citizens over 65 who are subsidized by active employees. The state renders financial support for around 4% of all citizens, including persons on childcare leave, registered unemployed persons and persons providing care for disabled persons. This group of persons who do not take part in compulsory health insurance also includes persons covered by voluntary insurance.

Figure 1. Here is a summary of the consolidated budget expenditures for health care in 2016-2019
medical agreements [15. p. 25-26]. This reflects the principle of solidarity of medical insurance in the act, when the working population covers a part of the needs of the disabled and socially vulnerable categories of the population.

Sandra Victoria Nei fairly points out that the health care system in Estonia functions in accordance with the Bismarck Model of Health Classification offered by the OECD. Based on this, the reforms implemented in Estonia recently implemented in health care system were appropriate. Considering this, as far as we know, they have demonstrated the best results for the current health care system in Estonia, but despite the above, the continued growth of funding for the health care system (fund filling) is the growing concern.

The health care system in Estonia functions according to the lines of the Bismarck model from the OECD health care classification. Based on this fact, it was established that the recent health care system reforms have been sensible. Considering what is known this far, they gave the best possible results to the present health care system in Estonia but in spite of this the sustainability of the healthcare system financing is an issue of growing concern [16. p.111].

Indeined, internal labor migration in the EU Member States, together with the general tendency towards ageing process of the European population, necessitates the financing of the medical sector to maintain the proper level of providing medical services to the population. It should be noted that family physicians in Ukraine can sign declarations with patients, who will soon leave for work in the EU, while the salaries of such physicians will be proportionally calculated to the number of signatories of the declarations. V.I. Teremetskyi, O. M. Muzychuk, E.Y. Salmanova, D.V. Kaznacheyeva and S.V. Knyshe focused attention to this issue in their works [17].

In general, the experience of these EU states demonstrates the positive and negative aspects of both organizational structures for building health care systems. We believe that the key aspect to implement the reform in Ukraine is the emphasis on a succession of changes and flexibility in finding the best possible directions for the development of the national system. Ukraine should pay attention to the possibility of creating a full-fledged state fund of compulsory health insurance instead of a service provided by the NSHU.

The key to the experience of foreign countries is to ensure human rights, especially its vulnerable groups: minors, handicapped persons, pensioners, etc. Therefore, it is advisable to develop and implement state medical programs for the support of pensioners in order to ensure an increase in the average life expectancy in Ukraine, as well as to support the active position of the population of Ukraine during the third age.

L.I. Danylchenko correctly noted: “The choice of the health care model must fully comply with the current situation in the country, in this regard the transition to insurance medicine should be implemented taking into account the welfare of the population, the possibility of paying a part of health services while maintaining appropriate social guarantees for the poor layers of the population” [18, p. 14]. Implementation of the medical reform in Ukraine, which in the perspective should improve the health care, nowadays complicates the implementation of medical rights by citizens.

Thus, we may name the main miscalculations of the reform of the medical system in Ukraine, they are: a) the absence of a clear benchmark in the formation of a perspective health care model on the basis of compulsory medical insurance (SHI) or on the basis of state health care (NHS); b) the lack of practical implementation of the changes and innovations declared by the concepts and plans; c) insufficient provision of medical rights of citizens during the transition period.

CONCLUSIONS
The authors of the article have stressed the main mistakes of the national health care system in accordance with the concept of medical sector reform. The authors have revealed positive international practices that can be implemented for the real improvement of medical human rights in Ukraine, namely the experience of Lithuania, Latvia and Estonia. It has been proved that the ongoing reform of the health care system in Ukraine needs to be reviewed and optimized in order to achieve concrete practical results. It has been offered to consolidate a perspective model of the Ukrainian health care system, its principles and guarantees of immunity on the legislative level. Populism and speculations on individual achievements in the health care sector should not serve as a criterion for the effectiveness of the reform. The assessment of medical reform should characterize it in the complex dimension, rather than in accordance with certain stages.

Search for the optimal health care system for Ukraine is a perspective topic for scientific research, since Ukraine’s national legislation is approaching the EU standards that requires greater integration of health care systems into a single European medical space.

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