PRACA POGLĄDOWA
REVIEW ARTICLE

MEDICAL INSURANCE AS A DIRECTION OF REFORMING THE HEALTH SYSTEM IN UKRAINE

Nadia S. Vasilevskaya[1], Olena V. Bailo[2]
[1]ODESA NATIONAL MEDICAL UNIVERSITY, ODESA, UKRAINE
[2]ODESA I.I.MECHNICOV NATIONAL UNIVERSITY, ODESA, UKRAINE

ABSTRACT

Introduction: The right to live, the right to healthcare and medical care insurance, which are affirmed at the constitutional level in Ukraine, are exercised by organizing the healthcare system with the due consideration of all social groups of people. The current state of healthcare funding in Ukraine does not encourage the conditions under which the quality medical care is provided to the population as needed, especially to the socially disadvantaged group of people. The formation of marketing system of management in Ukraine, the declaration of it as a socially-oriented country, results in the necessity to carry out healthcare reforms and to implement new systems of funding. The special emphasis in the process has to be given to the development of the insurance.

The aim: To study, to evaluate and elaborate proposals towards the justification of the changes in the healthcare funding through the reforming the system of medical insurance.

Materials and methods: Laws and regulations of Ukraine and related countries are analyzed in the article (by methods of comparison, analysis, synthesis, deductive approach, and scientific abstraction and generalization).

Review: The main forms of healthcare funding (on account of voluntary, compulsory and mixed insurance) were found out. Also, the special features of medical insurance in different countries based on the generalized models were investigated. As a part of the research, the condition of medical (voluntary and compulsory) insurance in Ukraine was analyzed and, as a result, the issues hindering its development were defined.

Conclusions: The model of insurance for implementation in Ukraine had been defined, as well as the condition of reforming system in compulsory insurance such as "taxes-budget-agency" with the stages had also been estimated. The possible consequences of medical reforming in Ukraine and the possible ways to improve the process of insurance in medical area were specified.

KEY WORDS: medical insurance, reformation, healthcare

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INTRODUCTION

The modern state of medical care in Ukraine is complicated, both financially and structurally. The main features of medical care are insignificant expenditures on health protection, inadequate and irrational distribution of resources in the system, high frequency of health seeking behavior, the shortage of appropriate medical services at the primary level, as well as the corresponding infrastructure. Medical field in Ukraine requires fundamental reforms, which is the major mission of modern times.

The experience of numerous developed countries witnesses about the successful reformation of the medical field through medical insurance and consolidation it as the platform for funding of the medical care system.

In accordance with the recommendations of the World Health Organization, funding of the healthcare system in a country is to be 6% of GDP. The expenditures in Ukraine were UAH 57 billiards in 2017. Expenditures for health care did not even reach 2% instead of recommended 6% the same year.

In that regard, there is a need in new forms of financial redistribution of medical expenditures. Only in 2018, the political decision to initial reforms (the systems of family doctors) was made. There were changes in emergency system too. Guaranteed package of medical services under medical reform, which refers to the formation of family doctor institution, changes in the system of emergency and immediate care, incorporation of ideas in medical insurance towards the proving the mandatory guaranteed package of medical services at the proper level for each separate individual.

At the same time, despite the fact that medical services will be provided on an insurance basis, the development of obligatory medical insurance as a legal institution is in stagnation. There is no stability in political area, the ambiguity of priorities in funding of medical care, the lack of meaningful and integrated concept from the Ministry of Health regarding the reforming of the field. The formation of a new executive body as a national insurer – the National Healthcare Service and all the previously mentioned factors launched the discussions about the necessity to implement obligatory medical insurance and appropriate legal and regulatory relationship in the area of medical services.

THE AIM

The hypothesis has been put forward in the study that the obligatory medical insurance is an important step for the improvement in the system of health care funding and for the improvement of health services. To achieve the set aim, the following questions must be solved: - to study the experience of foreign countries in the area of medical insurance; - to identify the condition of medical insurance in Ukraine; - to find out the directions of reforming the health system.

MATERIALS AND METHODS

The methods of comparisons (comparing the system of medical insurance in different countries of the world), analysis and synthesis (for defining the concept of medical insurance), deduction and induction (for defining cause-and-effect connection of medical insurance and population's health), scientific abstractions based on generalization (while formulating the conclusions) have been used in the study.

REVIEW AND DISCUSSION

The lack of the unanimity while formulating the term of "medical insurance" negatively affects the understanding of this legal phenomenon. In accordance with the article 7, subsection 1 of Ukrainian Act on Insurance [1], there are five types of obligatory insurance in medical field: - medical insurance (paragraph 1); - personal insurance of medical and pharmaceutical workers (except those who work in institutions and organizations that are financed by the government) in case of infecting with immunodeficiency virus while performing the duties (paragraph 2); - insurance of life and health of the veterinary service workers (except those who work in institutions and organizations that are funded from the State budget of Ukraine); - insurance or workers (except those who work in institutions and organizations that are funded from the State budget of Ukraine) who are the participant of providing psychiatric help, including those who provide care over the individuals who suffer from mental disorders (paragraph 13); -insurance of medical and other workers of the state, communal health care organizations and the state scientific organizations (except those who work in organizations and institutions, which are funded from the State budget of Ukraine), in case of infectious disease, related to performing their professional duties under conditions of heightened risk of infecting with the contaminators of infectious diseases (paragraph 19).

According to A. B. Kirichenko [2 p.93], the obligatory medical insurance is the "mechanism of health care funding, which is the integral part of the state social insurance, and which provides equal opportunities for medical care among all citizens. M. M. Sadovenko [3 p.139], in his turn, considers such insurance as a constituent part of social insurance, which is based on obligatory participation of the citizens, enterprises or businessmen in funding of health care directly or through medical insurance companies or organizations. According to T. A, Govorushko [4 p.109], medical insurance is an insurance in case of health loss for any reason, including illness or accident. It can be provided both in voluntary, and in obligatory forms.

Types of insurance (state, obligatory, voluntary and their mixed versions) acknowledged at the state level, define the organizational forms of health care. In a separate way, these forms are not used, however in some countries, they take the dominating position. For example, the state medical insurance (voluntary or obligatory) dominates in Denmark, Island, Canada, New Zealand, Norway and Finland, whereas the private medical insurance is dominant in the USA and Israel. In such countries as France and Japan, medical insurance is the part of general system of social insurance. In such countries as Belgium and the Netherlands, Germany and Switzerland, government regulates work of different independent funds.

It is necessary to note that to reform the medical insurance in Ukraine, it is appropriate to look into the experience of foreign countries. Thus, the main form of guarantee that the medical service will be provided properly in the US, is the private insurance (both group and individual). Private insurance covers the significant amount of Americans, whereas the state insurance covers only some categories of the population: elderly people and state employees.

Many Americans, who do not have private insurance, fall under the actions of the state programs of health care: the system of Medicaid is for those people whose income is lower than the federally defined income level (it is necessary to provide the documentary evidence of a low standard of living for this sort of insurance), Medicare is for patients who are over 65, Medicare Part D (includes also access to prescribed medications at reduced rates), SCHIP is insurance for children (from the families which not relate to Medicaid, but not solvent enough for obtaining private insurance), private systems (as a rule, 60% of Americans receive insurance on account of employers, and only 9% can afford the given type of insurance by themselves), COBRA is for those individuals who lost the jobs (is given temporarily, considering the reason of work termination), PCIP is for people with high risks (separate type of medical insurance for those individuals with significant chronic diseases). Also, because of the decrease in the number of insured individuals, which in its turn is a result of financial incapability to enter into the Insurance Contract, Americans were included to the program of Health Insurance Marketplace. Such system helps the population to find for them such an insurance company and insurance scheme which suit their needs and financial condition. The great number of expenses on medical service in the US is covered on account of voluntary medical insurance, which is paid by employers and the state. However, the population is responsible for paying the considerable part of expenses for medical services. These payments are generally considered as the mechanisms for regulating cost recovery Americans receive insurance on account of employers, and only 9% can afford the given type of insurance by themselves),

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There is a very clearly defined system of the relationship customer-insurance company – doctor in the US. The special attention is given to the list of medicines and the schemes of treatment. In general, it can be said that despite the considerable expenses on medical insurance in the USA, the individuals receive high quality medical services in full, and the presence of medical insurance make them even more advantageous, regarding the prices for each separate type of medical services.

Among the European countries the experience of France seems to be very appealing. There is a system of obligatory medical insurance. Medical insurance in France originated in 1910, at first in a way of mutual funds, and then starting with 1928 those mutual funds were transformed into insurance companies.

Nowadays, each citizen must have a Carte Vitale card to pay for services [6 p.168]. Although it covers only 75% of expenses, in case of an appointment with a very specialized doctor, it covers only 30% of the visit cost. 100% can be covered only in case of accidents at work, and also such privileges are given only to disadvantaged groups of population. Apart from that, private insurance is extremely popular with French, as the most part of French consider state insurance as insufficient. Nonetheless, French system of healthcare works well, as there is the highest average life expectancy in Europe. It is important to note that French system of health care provides even access as to state organizations as to private ones. Except the obligatory state insurance there is a system of voluntary insurance and local funds of social assistance. Owing to the latter, insignificant number of uninsured individuals have access to medical services.

The first insurance company in Germany, which offered medical insurance policy to the customers, appeared in 1848. In German system, the state does not fund the health protection (with the exception of some sectors), although provides the formation of insurance funds by means of employers and employees. The state performs the monitoring function over the whole system of medical insurance, which is decentralized. There are approximately 1200 insurance funds – Krankenkasse, which were formed on a territorial or professional basis. In such a way, the state insurance is the basis of health in Germany [7]. There is an established by the state sum of average annual salary (57600 Euros per year) when the citizen has the right to choose whether he needs an insurance or to choose between the private and the state insurance. Due to the fact that the state increases the average salary rate every year, more and more citizens are obliged to pay 7.5-8% of their annual income. It should be noted that insurance covers the cost of 95% services provided. As in many countries with the similar system of medical insurance, such insurance does not cover the appointments with the specialized doctors (for example a dentist), but some medical cash registers, in their turn, offer different service packages, relevant to different groups of population

Medical insurance in Russia is rather specific. Medical institutions, in their turn, perform their activities on the account of obligatory insurance contributions from the wages, which the employers are obliged to pay. The territorial programs were also based on the federal system's basis. In such programs there is a list of diseases, diagnostics and treatments which are performed on account of state money. The citizens may receive medical help of emergency outpatient type, in outpatient hospitals or at hospital. The contributions are distributed in the following way in the system of compulsory medical insurance: all businesses and organizations in the territory of Russian Federation allocate money in the amount of 5.1%from the payroll fund to the funds of obligatory medical insurance each calendar month. In case if an individual is qualified as unemployed, the contributions to the funds are done by the state on his benefit. At a later stage, the accumulated savings of insurance funds are evenly distributed among all the population in all regions of the country. Therefore, the insurer and medical insuring company enter into an agreement, which is the basis of this type of insurance. As a result of concluding a contract, the insurance company commits to organize and fund the insured person with the appropriate medical services in full amount, and who, in his turn, becomes an owner of medical certificate of insurance [6 p.166].

The organization and performing obligatory medical insurance falls into the state powers. In particular, the state articulates the main principles of obligatory medical insurance, adjusts the size of insurance contributions, and establishes special state funds for its accumulation. Obligatory medical insurance in Russian Federation has general nature, in other words, it covers all the population without any exceptions. The main goal of medical insurance is an accumulation and capitalization of insurance contributions, as well as provision of medical services to all the population, funded from the fund of obligatory medical insurance under the established by the state conditions and in guaranteed amount. From this perspective, the field of obligatory medical insurance is to be viewed from two aspects. First of all, obligatory medical insurance is a constituent in the system of social security on equal terms with the social insurance. At the same time, medical

insurance is a way to supply the systems of health care with extra money, except the assets, which are allowed from the state budget.

Thus, the special features of medical insurance in Russian Federation are: - the insurance proceeds are performed in a form of service; - the monetary aid is not provided, instead of which the services are paid. There is no division while providing medical services.

Medical insurance is in two forms – obligatory and voluntary. Each of these forms has its own features and peculiarities: procedures, organizational and legal principles and financial mechanism of implementation. Relating to the system of healthcare in Russian Federation, obligatory medical insurance has its own advantages, quite attractive to the population, since it enables them to receive medical services in a wide range of diseases for free, and also, insurance certificate is formalized only once.

The world experience of in medical insurance is diverse, although none of the models of health care is impossible to reproduce 100% without the due regard of national peculiarities. The analysis of the world practice in the area of healthcare funding based on the obligatory medical insurance, enables to feature its main peculiarities: - at first, social medical insurance can represent itself, as the main or additional financing of health care in foreign countries; - secondly, there are several approached to forming the funds of obligatory medical insurance: a) one fund for all the population (such funds are in Korea, Hungary, Turkey, Poland, Luxembourg and Slovenia); b) some centralized funds, maintaining service for the definite regions in the country; c) funds, maintaining service of the population in the same region, but do not compete (such cases occur in Austria, Belgium, France and Japan); d) some funds, either state or private ones that compete (such cases occur in Germany, Netherlands, the Czech Republic and Switzerland); - thirdly, different amount and procedures of making a contribution to such funds of obligatory medical insurance occur: a) single rates of contributions for the population of the country; b) share of a worker's contribution and an employer's contribution separate; c) contributions may be limited (in regions, in different categories of payers); d) additional contributions or deposits not related to the labor compensation are available [8 p.42].

Thus, European countries conduct the provision of the majority of healthcare expenses with the help of obligatory medical insurance. France and Germany provide almost ¾, Estonia and Romania almost 2/3, Poland and Hungary provide almost ½ of all expenses. Sharing the same opinion as A. B. Cherep, who believes that accumulated long-term experience in the area of medical insurance speaks for high efficiency of different models and systems of medical insurance and health insurance [9 p.22].

However, medical insurance has not got widespread in Ukraine. In spite the fact that almost 60 insurance companies and an Association "Ukrainian Medical Insurance Agency, which includes 28 insurance companies in Ukraine, representing it in 12 regions and Kiev, function in the country, only 5-6% of Ukrainians have the certificates of voluntary medical insurance. And what is more, such insurance dominates in corporate area. This is due to the fact that the cost of individual medical insurance is significant; there is such a position that young people are young enough and nothing can happen with them; medical treatment is provided but relies on the word of mouth; the thought prevails that despite medical insurance it is still necessary to pay in the hospital; the trust to insurance companies is absent. All insurance companies offer almost the same programs of voluntary insurance with the same package of services, with the registration in the same hospitals or clinics, with the provision of similar medical services. In view of this, we think that the system of voluntary medical insurance must be complemented with obligatory medical insurance.

It is necessary to note that there is a list of problems, hindering the development in medical insurance area in Ukraine. They are related to out-of-date material base; the shortage of medications; negative rate of demographical development of the country; increase in the morbidity rate; low rate of specialist's training in medical and insurance areas; the lack of eligible remuneration for doctor's work in the form of salaries and bonuses; medical corruption; avoidance of obligations by insurers in the area of paying the treatment of insured individuals; low quality of legislation, regulating medical insurance; different vision of the model by civil servants, insurers and doctors, on the basis of which medical insurance is to be based on, and first of all, its obligatory form; low level of population's awareness in understanding the possibilities of insurance medicine. The reform, having been initiated in Ukraine, must result in the changes of the model of medical insurance. Similar model which is called "taxes-budget-agency" functions in Italy, Canada, Spain, the Nordic countries and Great Britain. The essence of this model reduces to the introduction of medical insurance without any additional contributions and deposits; the introduction of the guaranteed packet of medical assistance which involves defined set of medical services and medications.

Insurance contributions in the country envisaged in the Internal Revenue Code. According to many experts, the introduction of additional obligatory contributions from the salary is inappropriate under crisis economic conditions in the country. For this reason, the model of financing envisages that money for covering the medical expenses will go to the National Health Care Service in Ukraine from the state budget. In this regard, The Law "About the Financial Guarantees of Medical Care for Population" and "About the Access Program to the Quality of Medical Services in the Rural Areas" were enacted and the Conception of Reforming in Financing of the Health Care in Ukraine was approved too.

According to introduction of such a model, three stages are covered: preparatory stage has already finished – it lasted from 2016 till 2017, in 2017 the implementation stage started, its active part was in 2018, when reforming was provided with the first medical assistance (family doctors, pediatricians and physicians). The final stage takes place

in 2019-2020 – at the level of specialists of outpatient services (cardiologists, otolaryngologists, gastroenterologists and others).

At the same time medical institutions embarked on the course of autonomization and are obliged to be granted the status of institutions and become the main providers of social health care in the nearest 3-5 years. The relationship between them and the central state fund of medical insurance are to be based on the basis of agreements with the service descriptions, which are funded by insurer (there will be stated he necessary volume of expenses and the proper vision of cost prices on the service, which will define the price).These descriptions, in their turn, are forming the insurance plans or packages, which define the status of such insurance package as the State Program of Obligatory Medical Insurance under the conditions of obligatory state medical insurance [10 p.5].

On account of the insurance agency funds (of National Health Care Agency in Ukraine), medical communal companies have the possibility to compete. Such companies, in their turn, gain the possibility to provide the commercial services out of the state program of medical insurance.

Rud V. is sure that obligatory medical insurance is going to ensure additional cash flow to the field and is going to enable the system of health care in Ukraine to become more flexible, dynamic and functional. In the opinion of the scientist, the introduction of mandatory state social medical insurance is going to provide the equal access to medical services by to categories of population. Although the viewpoint of a scientist is that this process must be followed by enhanced monitoring of the state over the functioning the funds of social medical insurance and the condition of the management. Insurance is going to stimulate the quality of the services, rendered to the population, and hold them accountable in accordance to the international standards [11 p.239].

We consider that for further reforming of obligatory medical insurance, the relationship between high medical institutions, postgraduate institutions together with the medical institutions, monitoring the effectiveness and the quality of medical services, must build credibility. Apart from that, the special attention must be paid to the function of interaction with the insurer towards the definition of the factors in the guaranteed volume of medical assistance, established by the state and its quality.

The list of problems related to the experience of foreign medical insurance and introduction of this experience in Ukraine requires the further discussion. Apart from that there is a need for more detailed discussion of the progress in the reforming of medical insurance in Ukraine, the mechanism of incorporating voluntary and obligatory insurance and formation of the complex legal base for functioning of medical insurance.

CONCLUSIONS

The experience of foreign medical insurance was defined in the course of the study, which justifies the high efficiency of different models combinations and the system of medical insurance. Analyzed state of medical reforming enables to come to a conclusion about the possibility to introduce such a model of funding of medical expenses that will guarantee the protection of the population in Ukraine in case of a disease at the state level, and also will address the corruption while distributing the financial resources and while rendering medical services.

Reforming of the health care in Ukraine must consider some peculiarities, namely:

- The transition from budget funding of health care on specific articles of expenses to funding under long-term stable legal norms, which will taka the due account of peculiarities and focus of medical institutions;
- Incorporation of budget financing of medical institutions with the development of insurance medicine and commercial services provided to the population, and maintaining the service to the companies and organizations on a contract basis;
- Enhancing the institutional autonomy, increasing the initiatives of work communities in addressing the issues of operational activities and social development;
- The relationship between the remuneration, social development and material incentive, depending on the final result in the activities of medical institutions, the quality of medical services and efficiency of work;
- Involving different forms of enterprises, including lease relationship, individual work, and the flexible system of remunerations.

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CORRESPONDING AUTHOR
Olena V. Bailo
Odesa I.I.Mechnicov national university
Dvorianskaia street, 2, 65001 Odesa, Ukraine
tel: +380972905038
e-mail: m_helen_15@ukr.net

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