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THE WORLD TRENDS OF DEVELOPMENT OF STATE REGULATION IN THE FIELD OF HEALTH PROTECTION

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Abstract. *The authors show that health care systems were formed under the influence of specific historical, economic, social and political factors. But with a certain degree of convention, all existing systems are divided into the following three main models: budgetary one (Beveridge system); social insurance (Bismarck system); private one.*

The authors think that no developed country in the world can provide all the needs for medical services, medicines and other technologies exclusively from public funds without the involvement of private insurance programs and co-payments. However, in practice, all developed countries ensure equal access of all citizens to the necessary health care services, benefits are provided for broad groups of the socially vulnerable population.

The authors conclude that the expected probability of survival to 60 years of age in 2048 is higher than the life expectancy at birth at 9,2 years that testifies to the effectiveness of world state policy in the field of health care of the population in a whole.

Keywords: *state regulation, public authorities, health sector, public policy, health care system.*

Introduction. From the middle of the 20th century, the development of health care in the world took place under the sign of intensive reorganization. Despite significant differences in the resource availability of national health care systems, their organization, efficiency of functioning, the reasons that led to the need for changes were due, first of all, to a lack of funding.

In the health care of the richest countries, such objective factors as the technological development of medicine, the aging of the population, organizational costs, etc. required a constant review of strategies. The low standard of living of the population, low health indicators, increased mortality, threats of the spread of infectious diseases became the main reason for changes in the health care of poor countries.

At the same time, the nature of organizational transformation systems of health care was determined not only by the specifics of the problems that arise, but also by the state of accumulated theoretical knowledge in the field of reforms and established global practice. International organizations were at the forefront of the health care reform process all this time, the strategies developed by them were implemented, that determined the directions of health care development in the world for a long period of time and continue to be implemented to this day.

According with the given directions, the development of health care from the extensive period of increasing of staff and hospital equipment of the first half of the 20th century was consistently carried out in the direction of introducing of additional sources of financing in the form of social insurance systems, attracting funds from

consumers of medical services, state support for the least well-off social groups, increasing the economic efficiency of health care based on organizational changes in the system of providing medical care.

Literature analysis. The authors (Caron, R.M., Noel, K., Reed, R.N., Sibel, J. & Smith, H.J., 2023) note that health care relies on the experience and cooperation of public authorities with health systems. Health promotion, health care, and disease prevention serve as interconnected constructs to fulfill the mission of maintaining public health that ultimately provides healthy populations.

The authors (Carey, G., & Friel, S., 2015) claim that Many social-level factors that influence health-social determinants of health – exist outside the health sector, at different government levels and in other large institutions, including non-governmental organizations and the private sector. This has created a growing interest in shaping and implementing public policies that will contribute to better and fairer health outcomes.

The authors (Stanton, E. & Bell, A., 2019) think that health is a key function of Public Health England, covering emergencies, resilience and response, environmental protection and infectious disease control. The aim of this article is to discuss the role of healthcare, its structure in England and that therapists are integral to reporting, surveillance and action to protect public health.

The author (Awofeso, N. Leprosy, 2011) shows that health policy can be described as a written administrative document detailing the general and deliberate course of action (or inaction) for management through decisions and achieving rational outcomes. The excess of explicit statements of intent by governments and health policy administrators to define health policy may reduce policy analysis to abstract regulatory generalizations.

The above stated allows us to note that many authors have devoted their scientific achievements to health care issues in the world in modern conditions, but the systematization of world experience concerning state regulation in this area

remains an urgent issue. Accordingly, **the purpose of the work** is to observe the world trends of development of state regulation in the field of health protection.

Methodology. The work uses a systematic approach, according to which all processes and phenomena of state regulation in the field of health care were analyzed in integrity and interdependence. The following scientific methods were used that made it possible to obtain basic theoretical results: abstract-logical one, methods of analogy, comparison, induction and deduction. During the analysis of the current state of the mechanisms of state regulation of development of the healthcare sector in the world, a statistical method was used (determining the effectiveness of mechanisms for providing medical services to the population of the world, organizational mechanisms of state regulation of the development of the healthcare sector and regulatory mechanisms for the development of state regulatory potential in the healthcare sector); method of comparison (critical understanding of methodological approaches, concepts, developments, models and proposals of leading scientists devoted to the peculiarities of mechanisms of state regulation of national health systems) system-analytical method (study of legislative acts and other regulatory documents). All these research methods complement each other and together provided the opportunity to comprehensively consider the subject of research.

Main part. Introduction of modern management mechanisms, development of market technologies, strengthening of regulatory functions of the state, primarily aimed at fighting poverty and overcoming inequality in access to medical care, as well as preferential stimulation of health care measures in the field of intersectoral cooperation, improvement of lifestyle, ensuring of a targeted approach to reducing the spread of socially significant diseases − all these methods were the essence of the trainings carried out starting from the second half of the 20th century. Based on them, specific strategies were formed in different periods of time, which were implemented in different countries with varying degrees of success. The key requirement of international organizations when choosing national strategies was to get the

maximum benefit from health care systems in terms of ensuring of the health of the population with limited resources [2; 4].

Health care systems were formed under the influence of specific historical, economic, social and political factors. But with a certain degree of convention, all existing systems are divided into the following three main models:

- budgetary one (Beveridge system);
- social insurance (Bismarck system);
- private one.

The most vivid example of a budgetary model is the UK health care system, which is financed mainly from tax revenues of citizens. The key provider of health services is the National Health Service, which reports to the Department of Health. It provides residents with almost the entire set of necessary medical services, medicines in hospitals and medical products free of charge. As for provision of outpatient leave with prescription drugs, the country has a balanced system of reimbursement of the cost of these drugs, which includes co-payments for the able-bodied population. Benefits regarding co-payment are established for socially vulnerable and low-income population groups. Thus, citizens under 16 years old, 60 and more years old, students of ophthalmology departments under 19 old, patients with diseases included in a special list, military pensioners and war invalids are completely exempt from co-payments for medicines. Moderate co-payments apply to ophthalmology and dental services. The state pays for travel to the place of treatment for the poor, and also provides a number of other important benefits in the field of medical services [5; 7].

Another example of a budgetary model is Australia, where the federal government provides the bulk of health care resources by funding two leading nationwide public programs – the compulsory health insurance system Medicare (Medicare) and the Pharmaceutical Benefits Scheme (PBS). Medicare covers 75% of the cost of inpatient services and from 85% to 100% of the cost of outpatient services. PBS provides vaccinations and payment of 80% of the cost of prescription drugs. In addition, the federal government provides funds to support public hospitals

and regional health care programs, as well as subsidies for long-term care services for the elderly and disabled. Together with state and territory governments, public health programs, psychiatric care, some dental services, rural, indigenous and veterans' health care are funded [9; 11]. The government regulates the markets for medicines, medical devices and private health insurance. Private health insurance plays only a supporting role, providing access to the services of private hospital institutions, as well as to the few services not covered by public funding. The state provides support to citizens who buy private health insurance policies by providing special budget subsidies and tax benefits.

The budget model of health care is also used in Greece, Denmark, Ireland, Spain, Iceland, Italy, New Zealand, Norway, Portugal and Sweden [1; 10].

In contrast to the budget model, the social insurance model is financed not from taxes, but from the contributions of employers to health insurance. Just like the budget model, it provides access to health care services for the whole or almost whole population. The difference is that organizations of various forms of ownership participate in the provision of medical services, and the state plays the role of guarantor in providing citizens with these services. In Europe, the social insurance model is most developed in Germany and France, but it is also used by other countries, including the Netherlands, Austria, Belgium, Switzerland, Canada and Japan.

In Germany, 90% of the population is covered by the national statutory health insurance system (SHI, Statutory Health Insurance), which consists of approximately 150 health insurance funds (hospital funds). The main sources of their financing are the contributions of employers in the amount of 15.5% of the income of the insured persons, and this total contribution is divided between them approximately equally. Every resident has the right to change the insurance organization at least once a year without temporary costs and paperwork. The principle of solidarity is strictly observed, according to which a healthy resident pays for a sick person, a young person pays for an elderly person, a working person pays for an unemployed person.

At the same time, the system covers almost all the necessary services, medicines and medical products, and co-payments of the population [3; 6].

In France, the entire population of the country, including even illegal immigrants, is covered by the mandatory health insurance system (Assurance Maladie Obligatoire, AMO). 90% of the financing of this system is provided by social insurance contributions, the rest is covered by taxes and excise duties. In France, the principle of freedom of choice for the patient is strictly observed: every resident of the country has the right to receive a referral to any specific specialist of his/her choice. There are several subsystems (schemes) of health insurance. The largest (it covers about 80% of the population) is the general scheme, which covers employees and their families. There are schemes that apply to private farmers and individual entrepreneurs, as well as government employees. Indigent citizens and the unemployed are insured under a special program for persons with an annual income not exceeding € 8,774 [5; 10].

The peculiarity of the private model is the absence of a single system of state medical care or insurance. Medical care is provided mainly during a paid basis, at the expense of private insurance. The state undertakes to finance only those needs of society that cannot be satisfied by the market (medical services for the poor, pensioners and the unemployed). The most famous example of such a model is the USA, where there is no national health care system covering the entire population. The United States remains the only industrialized country in which only to a limited part of citizens have state guarantees in the field of medical care. The basis of the country's health care system is paid medicine with the dominant role of private health insurance, which is characterized by a wide variety of plans. State health insurance is a separate category of the population within the framework of federal and mixed federal-state programs, such as, for example, Medicare and Medicaid. A significant share of the population (50 million people or 16%) is not covered by any type of health insurance [4; 7].

It should be noted that none of the models exist anywhere its pure form. Despite the fact that both the French and German models are social insurance, the state in both cases allocates significant funds for health care directly from the country's budget, which has become especially relevant in recent years due to the lack of health care resources. In Great Britain, not all the needs of the NHS are financed from general tax revenues: they form 76% of its budget. The remaining 24% is covered by employee health insurance contributions (19%), as well as other contributions and fees (5%) [9; 11].

Another example of a combination of two different approaches is the Canadian health care model. As a rule, it contains social insurance, but in many ways, it is similar to the state model. In Canada, universal access to health care services for 99% of the population is provided by the system of mandatory public health insurance Medicare plays an important role in this context. The main source of funding for Medicare is not employer and employee health insurance contributions, but federal and provincial tax revenues, as in the budget model [2; 10].

An important feature of the health care systems based on the Bismarck and Beveridge models is that the countries using these models (European countries, Australia, Canada and Japan) spend very serious funds on health care − at least 9–11% of their GDP. At the same time, 70% or more of the total costs are financed from public funds, which allows solving the problem of general coverage of the population with guaranteed medical services of appropriate quality. To increase efficiency and eliminate duplication of costs, single-channel financing (budget or health insurance funds) is used, but various additional sources are widely used to make the health care system financially sustainable [9; 11].

Another situation is observed in the USA, where more than 17% of GDP is spent on health care, but the state's share of health care financing does not reach 50%. The low share of public funding is compensated by a system of private health insurance for the working population, which relies on strong financial support from employers. The USA is the leader in financing, development and production of

innovative medicines and other medical technologies. In terms of the number of magnetic resonance imaging machines per 1 million inhabitants, they are second only to Japan, and in terms of the number of diagnostic studies using magnetic resonance imaging, they rank first in the world, ahead of Germany. However, the USA is significantly inferior to most European countries in terms of the efficiency of health care costs, showing lower indicators of the quality of medical care, such as life expectancy and infant mortality, compared to Europe. At the same time, according to the five-year survival rate of breast cancer patients − one of the most important indicators of the quality of health care used by the OECD − the USA is in first place [3; 7].

In this regard, it is necessary to assess the effectiveness of modern models of state regulation in the field of health care in the world. Figure 1 shows the probability (including forecast) of survival to 60 years of age during 1950–2048, figure 2 shows the life expectancy (including forecast) at birth, during 1950–2048 [9; 11].

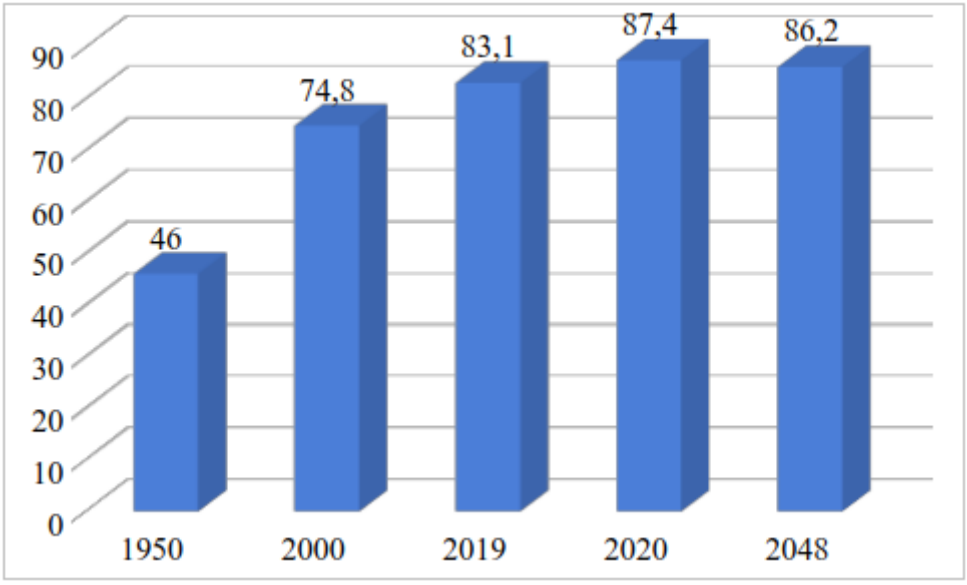

Figure 1. The probability (including forecast) of survival to 60 years of age during 1950–2048

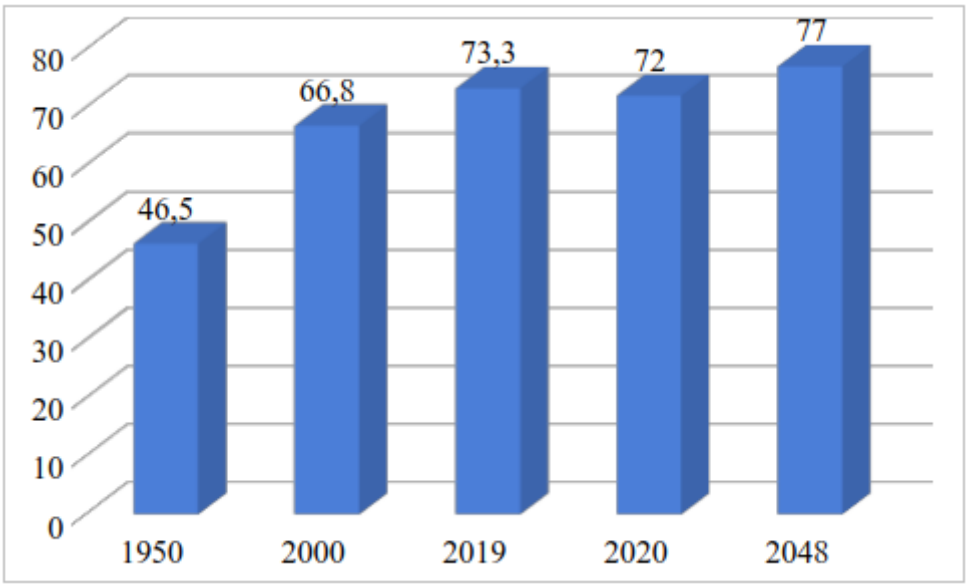

Figure 2. The life expectancy (including forecast) at birth during 1950–2048

Comparing Figures 1 and 2, it is possible to see that the expected probability of survival to 60 years of age in 2048 is higher than the life expectancy at birth at 9,2 years that testifies to the effectiveness of world public policy in the field of health care of the population in a whole [9; 11].

Conclusions. Thus, from the standpoint of health care policy and social responsibility of the state, the traditional classification of health care systems based on the Bismarck and Beveridge model loses its meaning. More important is the achievement of general coverage of the population with health care services of appropriate quality, as well as the elimination of duplication of costs. The success of health care reforms depends not so much on the sources of funding, but on the availability of resources, their rational distribution and more effective use, as well as the improvement of the quality of medical services. At the same time, it does not matter what sources are used for their payment: whether it will be funds from the budget or mandatory or even voluntary health insurance. It is no coincidence that even in the USA, where social guarantees of the state are traditionally weaker than in Europe, Canada and Australia, a reform aimed at expanding the coverage of the

population with guaranteed medical services is being carried out. It is assumed that thanks to the reform, 32 million people who previously did not have insurance will be able to use health insurance.

No developed country in the world can provide all the needs for medical services, medicines and other technologies exclusively from public funds without the involvement of private insurance programs and co-payments. The scope of programs of state guarantees for the provision of medical care is not the same in different countries, often the guarantees for the provision of specific types of medical care, provision of medicines and medical products are not prescribed or not clearly prescribed in regulatory documents. However, in practice, all developed countries ensure equal access of all citizens to the necessary health care services, benefits are provided for broad groups of the socially vulnerable population.

Discussion. The analysis of individual strategies for the development of health care systems in the world showed that today there is an intensive search for the most effective methods of state regulation of health care. The historical experience of health care reform shows that development takes place mainly in two directions: strengthening the mechanisms of centralization of management at all levels and strengthening the patient-centered model of care. At the government level, priority is given to the strategies of state regulation of various sectors of the economy and the social sphere with the aim of taking into account their impact on the health of the population, combining the interests of the public sector and the personal interests of citizens in observing the principles of a healthy lifestyle, creating conditions for justice ensuring in providing for the population medical help. In the field of medical care management, the trends of regulation (state and self-regulation) in the market of medical services are strengthening, based on the use of mechanisms of “regulated competition"”, the strategy of “distribution of resources”, including increasing the role of primary care in financing further stages of medical care, as well as the spread contractual obligations, wide use of various forms of self-organization of integrated structures. The strengthening of the individual approach to the treatment of patients is

realized in the implementation strategies of “disease management programs”, “patient-oriented primary care”, “humanitarian model of health care”, formation of “therapeutic communities”. The given data indicate that there has been a change in the management vector of health care development in the world from the classical liberal one (priority of market mechanisms) to the strengthening of state regulatory mechanisms.

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