

**THE PROBLEM OF MEDICAL INSURANCE IN
TRANSITIONAL COUNTRIES: LESSONS FOR UKRAINE**

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Submitted to
Central European University
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In partial fulfillment of the requirements for the degree of Masters of Arts in
Political Science

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Budapest, Hungary
2008

Abstract

Ukrainian health care requires urgent reform which should affect the fundamentals of the system. Current budget financing is not sufficient to cover even the basic needs of population and the system of health care is almost collapsed. This research argues for necessity of fundamental reform that will change the system from budget financing to the system of general mandatory health insurance. This system is considered to be more efficient and acceptable for Ukraine than the current one with predominantly direct payments and severe budget underfinancing. The experience of other transitional countries can be used for the elaboration of such a system in Ukraine. The research will be based on a review of literature and data from primary and secondary sources and legislative proposals in Ukraine concerning the reformation of health care system. Not individual cases but the general trends of the health care systems of transitional countries of Central Europe and Russia will be analyzed. The problems in the health care system of Ukraine are greater than in chosen transitional countries. That is why very fundamental changes are needed; among them the most important one is the amendment to the Constitution.

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Introduction

The problem of reforming the Ukrainian health care system is very urgent due to the severe crisis in this sphere and its importance for the social prosperity of the nation. As it is stated by the World Bank “the mechanisms currently in place neither reflect the health care needs of the population nor account for regional characteristics of health service provision. There is also little incentive for rational use of resources or cost control over health facilities”.¹ In my opinion the reason for the severe crisis in the Ukrainian health care system is that this system is extremely obsolete and does not function in the new conditions of the market economy. The system has almost collapsed because budget funds do not cover even the basic needs of the branch and thus are incapable of providing the majority of the population even with basic medical services. The majority of the population has not access to qualitative health care but at the same time resources are spent in a very inefficient way. A solution to this problem is providing other than budget sources to finance health care and particularly the introduction of general mandatory health insurance system. I believe this system to be more appropriate for a state that has expressed a wish to move towards a free market economy and towards European integration. For example, as it was stated in The Programme of Cabinet of Ministers of Ukraine from January 16 2008 that government takes responsibility for bringing into line the health care legislation in Ukraine with the legislation of EU.²

However there are also some obstacles to the introduction of such a system that are lying in legal, financial and institutional spheres. If we assume that this system is so good and has wide

¹ Valeria Lekhan, Volodomyr Rudyi, Ellen Nolte *Health Care Systems in Transition. Ukraine* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004), 25, <http://www.euro.who.int/Document/E84927.pdf> (accessed May 1, 2008)

² Society and health care: partnership for health, Vol.7 (January, 2008), <http://www.communityhealth.com.ua/> (accessed May 20, 2008)

support among Ukrainian politicians, as it was expressed, for example, in the Program of Government “Ukrainian break-through: for people and not for politicians”³ from January 16 2008, there is a question why this system has not been introduced so far in Ukraine. That is why I suppose that the topic of this thesis is very current and requires precise investigation.

From the point of view of Ukraine’s wish for integration into the European Union and for corresponding to the European standards, the experience of Central European countries is very useful as they had the same Soviet legacy that left a mark on health care system and then they to various degrees managed to transform this system into a more modern system that responds to the general transformation of state. Of course the differences in economic development and different legacy in these countries before the Soviet time can not be disregarded, but I still consider these countries as appropriate example for the transformation of health care system for Ukraine from the point of view of final goal of reforms. The experience of Russia, a country with similar problems in health care that managed to introduce the mandatory medical insurance, has great value for Ukraine from the point of view of the difficulties of the introduction such a system in a transitional country.

The models of health systems are precisely investigated in the existing literature. However there are not so many works dedicated to the investigation of the transition of the system from tax-based to social insurance scheme, except for European Observatory on Health Systems and Policies that has a more factual character than analytical. The problem of providing health insurance in Ukraine is not investigated at all as there is no empirical evidence of operating such a system. And the models that are sometimes proposed for the Ukraine from developed Western European countries and sometimes United States are not completely relevant

³ The Program of Government “Ukrainian break-through: for people and not for politicians”, Official site of the Cabinet of Ministers of Ukraine
http://www.kmu.gov.ua/control/uk/publish/article?art_id=104231107&cat_id=47292901 (accessed May 19, 2008)

for a transitional country. That is why the investigation of the experience of implementation of health care reform in medical insurance of transitional countries of Central Europe and Russia should be given attention for analyzing the appropriate models of health insurance and the way of its implementation.

The problems that are connected with the topic of this thesis are as following. First, the reformed health care systems of Central European countries are not ideal and still require improvements and amendments. So they can not be considered as indisputable pattern for the reform in Ukraine. Second, if we assume that Ukraine is able to follow the way of Central European countries there should be some common starting point for these countries and Ukraine before the reform launching, as this point I consider the end of command economy with the collapse of the Soviet Union. However the legacy before socialistic economy in Central European countries also can not be disregarded as well as starting differences in economic development. Third, there is a problem of adaptability of a proposed system meaning that even if it is possible to find a very efficient system of medical insurance based on the experience of Central European countries why will it necessarily work in Ukraine. For this purpose in my opinion great attention should be paid to the consideration of legal institutional and cultural prerequisites for the reform in Ukraine.

The purpose of the study is to analyze the current state of health care in Ukraine and mark some prerequisites and obstacles for reform. Then to provide some solutions based on the experience of Central European countries. My hypothesis is that as the health care system in Ukraine collapsed and the budget does not provide funds for health care in sufficient amount there should be some radical reform concerning the creation of social health insurance fund the shift of the burden from the state budget on this fund. The main purpose of this investigation and

the final result that is supposed to be reached is the application of a model of social health insurance system that operates in transitional countries to the Ukrainian context.

I support the idea that Ukraine should adopt general mandatory health insurance system with the division of financing and supply side. The state can not be dismissed of its main social functions and still should play an important role in health care; but rather as a guarantor and guard of the system.

The research will be based on a review of literature and data from primary and secondary sources and legislative proposals in Ukraine concerning the reformation of health care system, World Health Organization's reports on countries' health care in transition, statistical reports and internet sources will be used. The health care systems of transitional countries of Central Europe and Russia will be analyzed in their general trends rather than as individual cases. I will compare different models of health insurance and will argue that the most appropriate for Ukraine is the system of social health insurance, however, the peculiarities of this system are to be defined; in And particular whether it should be a system with emphasis on state regulation and budget donations or with private basis and market oriented and what is the ratio of budget donations, social insurance contributions and private incentives.

I will structure my research in the following way. First I will consider the main principles of health insurance, the role of the state in it that is very important for transitional countries and particularly for Ukraine. Then I will argue for the necessity of health insurance in a modern society. This part constitutes a theoretical framework for the research.

In the second chapter I am going to concentrate on empirical evidence from transitional countries of Central Europe and Russia in the implementation of reforms in health care main part of which was the introduction of the social medical insurance, motives for the reform and some

obstacles that countries faced during the reform process. I will investigate the current state of the health care in these countries, debates about the necessity of further reformation of the system, some advantages and achievements of these countries that can be used by Ukraine and some disadvantages of the system that should be avoided.

In the third chapter I will consider the peculiarity of the Ukrainian case, the current state of health care and starting point for reform. I will ground the need of the reform for Ukraine using for arguments such health indicators as general access to health care, coverage of the needs of the patients, demographical, health indicators, the health care spending. Then I will analyze the problems of transformation from the tax-based system to insurance based system in Ukraine and some difficulties that are lying in the legal sphere expressing the necessity of amendments to the Constitution, in institutional sphere and particularly the absence of necessary institutions of health insurance market and institutions of the supply side and in the problem of financing and the role of the state in providing medical insurance. I will also suggest some solutions to these problems that can be found in the experience of Central European countries while reforming their systems with regard to the peculiarity of the Ukrainian case. A lot of attention in my opinion should be given to the question of adaptability of the experience of other transitional countries in Ukraine as there can be a possibility that even some best experience and solutions will not work in Ukraine and in the worst case will have the opposite negative effect.

The final result that is supposed to be reached is finding some solutions in the experience of the reform of the health care in transitional countries that might be used during the reform of the Ukrainian health care system and specifically the introduction of social medical insurance. The research also hopes to define the way how they can be adopted by Ukraine in a most efficient way with sufficient saving of resources and funds.

Chapter 1: Health insurance as a core component of health care system in the modern world

This chapter constitutes theoretical framework for the present thesis. Before considering the problems of how insurance can be provided and how it works in given countries the question of what insurance is in itself, why it is needed and what makes people participate in insurance plans requires close consideration. Besides, there exist different models of health insurance from private voluntary to generally mandatory that operate in different countries. These different models and recent trends in reforms of health insurance will be considered. The study of peculiarities of different health insurance systems and especially of Soviet model of financing of health care that was operating in all transitional countries and was a starting point for reforms will help to understand the logic of acceptance of definite health insurance system by particular transitional country.

1.1 General principles of insurance

As it was stated by David Reisman, “insurance permits the pooling of risks and the sharing of uncertainties. In few areas of social life is the anxious individual more exposed to the potential buffering of a cruel fate than where it is unpredictable health in a unknown future that is stake.”⁴

He emphasizes that “insurance arises of uncertainty as to the need for and the cost of care to-come”.⁵ “A rational individual might be willing to pay an agreed fee to an insuring agency that takes over from him possible costs of unanticipated calamity. Not so where the contingency is a certainty: no rational individual will call it value for money to put down a known stake in exchange for a known reimbursement that is (after the deduction of profits and overheads) a

⁴ David Reisman *Market and health* (New York: St.Martin’s Press, 1993), 55

⁵ David Reisman, 56

smaller sum than that which had been paid in”.⁶ This particular feature of insurance relates to health sphere directly as illness arises as usually suddenly and its treatment might require substantial financial resources without delay.

Thus, “Insurance is a mechanism for transferring money from when it is needed less to when it is needed more. Insurance is more practical and effective than individual “saving for a rainy day” or attempting to borrow enough money to cover expenses after illness strikes. By pooling one’s risk with that of others who also purchase insurance from given insurer, an individual can secure some protection against the financial risk of ill health by paying a reasonable amount at regular intervals”.⁷ “The basic function of the insurance sector is to take the burden of risk off the shoulders of individual citizens and businesses by assuming those risks in their stead”.⁸

As for characteristics that insurance has, Morrison assumes that “there are two basic sorts of insurance arrangements: mutuality and solidarity. Mutuality includes most commercial insurance where applicants voluntarily pool their risk on a perceived risk basis at the time of taking out a policy. Solidarity includes compulsory insurance such as social or national insurance for health, etc”.⁹

“Insurance availability requires the existence of at least one organization willing to accept the risks and pay the costs when they arise”.¹⁰ Kornai writes about this organizational structure

⁶ David Reisman, 56

⁷ Janos Kornai and Karen Eggleston, *Welfare, Choice and Solidarity in Transition. Reforming Health Sector in Eastern Europe* (Cambridge University Press, 2001), 52

⁸ Tim Jenkins, *Risk in the Insurance Sector* (Risk and Capital Management Conference Proceedings, November 19, 1999), 40, www.apra.gov.au/RePEc/RePEcDocs/Archive/conference_papers1/risk_insurance_sector.pdf (accessed May 1, 2008)

⁹ Patrick J.Morrison, “Insurance considerations for individuals with a high risk of breast cancer in Europe: some recommendations”, *CME Journal of Gynecologic Oncology*, (July, 2000), 273
<http://www.cme.hu/dlObject.php?aid=17&/272-77morrison.pdf>, (accessed May 1, 2008)

¹⁰ Philip Jacobs, *The economics of health and medical care* (Maryland: Aspen Publishers, 1996), 83

of insurance: “Insurance imposes a third-party player between the consumer and the provider. Thus the health sector features a triad of consumer, insurer/payer, and provider. The presence of the third party insurer means that the demand price – the price that the consumer faces when buying the good – can be set somehow independently of the supply price – the price that the supplier receives when selling the good. (In fact, in most cases there is an important fourth party as well, a sponsor such as government agency or employer, which mediates the flow of funds between consumers and insurers or health plans, and also may or may not contribute to the costs of insurance).”¹¹

Insurance agencies try to “extrapolate probabilities from past experience and to rely on the law of large numbers for the purpose of estimating risks. Aware that no prediction is ever perfect, it will nonetheless be the conviction of the insurer that the predictions will be accurate enough for premiums to be set that bear an adequate resemblance to the underlying parameters of the probability distribution.”¹²

Kornai considers the peculiarity of insurance from other goods and services “in that the costs of supplying insurance depend on who buy it”.¹³ He notices that “in decentralized insurance market high cost consumers (for instance those suffering from chronic illness or older age-groups whose members fall ill more frequently and severely) buy an insurance policy that policy will be expensive to supply. In contrast, if infrequent users of medical care (for instance, healthy young people) enroll in a given insurance plan, that plan will be relatively inexpensive to supply”.¹⁴ In health sector it can have negative consequence in fact that people who are more in need will have to pay greater amount which they probably can not afford than those who does

¹¹ Janos Kornai and Karen Eggleston, 53

¹² David Reisman, 57

¹³ Janos Kornai and Karen Eggleston, 54

¹⁴ Ibid., 54

not need health provision urgently and may result in exclusion of the most needy from health provision.

The motivation for those willing to buy insurance is to protect himself and his family from unexpected dangerous events. “The willingness to insurer will be the most marked where the potential costs are exceptionally burdensome and the estimates risks neither so low as to be negligible nor so high as to be certainties.”¹⁵

Very important characteristic of insurance is asymmetry of information meaning that one party possesses more knowledge than another and can manipulate by this. “In the market of health insurance, it is often the demand side (the consumer wishing to buy insurance) who possesses more information about the transaction – his or her current and future state of health and propensity to use medical care – than the insurer supplying insurance. When information is asymmetric, however the premium may exceed or fall short of the actual cost of covering the loss, depending on who enrolls. Asymmetry of information about an individual’s health care needs can cause severe problems in any mechanism for health insurance”.¹⁶

“Always insurance is redistributive. In a multiple-pool society, however, the redistribution operates not simply within each pool: it is operative between the disparate pools as well. Such a bias will not, of course, be perceived as any great hardship by consumers fortunate enough to be classified as good risks”.¹⁷

Thus, insurance is very applicable to health sector where uncertainties are wide spread and where people have strong and crucial motivation to protect themselves against unexpected illness, as health is basic value for them. Important contradictions that influence the principles of general access and solidarity in health care arise if apply the characteristics of insurance on

¹⁵ David Reisman, 58

¹⁶ Janos Kornai and Karen Eggleston, 54

¹⁷ David Reisman, 66

health sector. First, the contributions for less healthy people are greater than of those who are fit; however, the demand for insurance is just the opposite. Second, as the main meaning of insurance is redistribution, healthier people have fewer incentives to participate in insurance that influences this very important principle. Third, as the information in insurance is asymmetric and in health insurance this asymmetry becomes crucial, there is constant need for a control in this sphere.

1.2 Financing of the health care sector: role of medical insurance

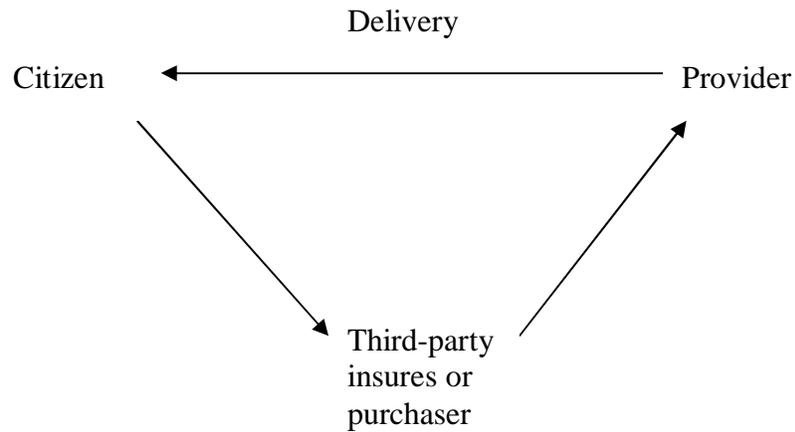
“The provision and financing of health care can be simplified as an exchange or transfer of resources: the providers transfer health care resources to patients and patients or third parties transfer financial resources to the providers (Figure 1). The simplest form of transaction for a good or service is direct payment. The consumer (the first party) pays the provider (the second party) directly in return for the good or service”.¹⁸

However, with the introduction of third party the system changes cardinally as it offers “interpersonal redistribution. To finance health care services, the third party must collect revenue directly or indirectly from the population it protects (this may cover the whole population or a subgroup of the population such as those who are employed). This revenue is then used to reimburse the patient or the provider”.¹⁹

¹⁸ Elias Mossialos et al., ed, *Funding health care: options for Europe* (Buckingham · Philadelphia: Open University Press, 2002), 2, <http://www.mcgraw-hill.co.uk/openup/chapters/0335209246.pdf>, (accessed May 10, 2008)

¹⁹ Vesna Bjegović and Dončo Donev, ed., *Health systems and their evidence based development* (Sprint-Beograd, 2004), 313, http://ph-see.snz.hr/Documents/Publications/PH-SEE_Book1_Full_HealthSystemsAndTheirEvidenceBasedDevelopment.pdf, (accessed May 10, 2008)

Figure 1

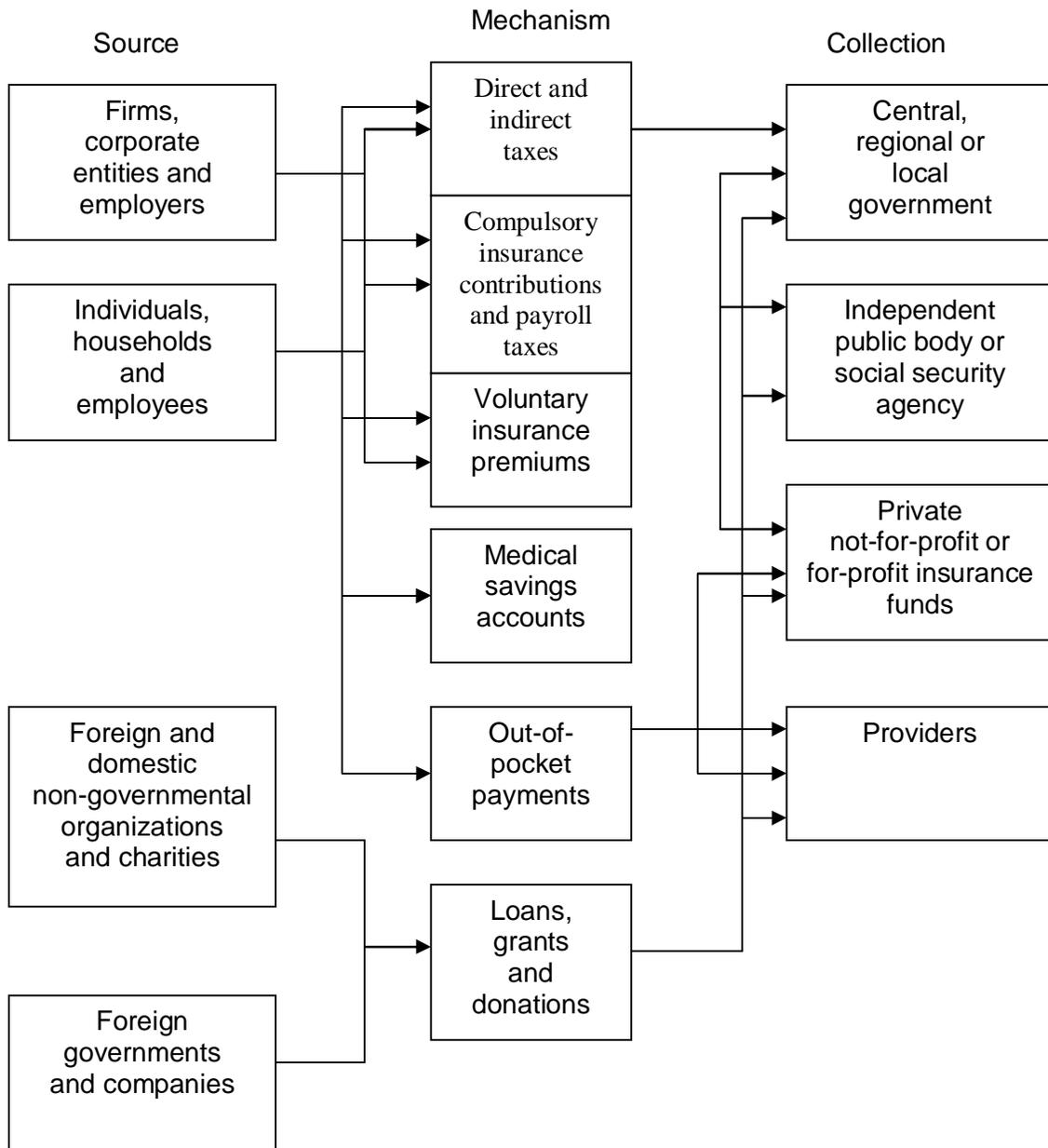


Source: adapted from Reinhardt (1990), quoted in Elias Mossialos et al., ed., *Funding health care: options for Europe* (2002),²⁰

Mossialos and others adduce developed scheme of possible ways of health care financing in examples of funding sources, contribution mechanisms and collection agents:

²⁰ Elias Mossialos et al., ed., *Funding health care: options for Europe* (Buckingham · Philadelphia: Open University Press, 2002), 3, <http://www.mcgraw-hill.co.uk/openup/chapters/0335209246.pdf>, (accessed May 10, 2008)

Figure 2



Source: Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin (Edt) *Funding health care: options for Europe*, European Observatory on Health Care Systems Series (2002).²¹

They say that this figure “illustrates the diversity of sources of funding, contribution mechanisms and collection agents and how these might interrelate. Funds derive primarily from the population (individuals and corporate entities). The funding mechanisms include taxation,

²¹ Elias Mossialos et al., 4

social insurance contributions, private insurance premiums, individual savings, out-of-pocket payments and loans, grants and donations. Collection agents can be private for-profit, private not-for-profit or public. The status of the insurers affects their motivation and incentives – that is, whether they act in the interests of shareholders or members”.²²

Tax classification for medical financing is classified by them as follows: “Taxes can be levied on individuals, households and firms (direct taxes) or on transactions and commodities (indirect taxes). Direct and indirect taxes can be levied at the national, regional or local levels. Indirect taxes can be general, such as a value-added tax, or applied to specific goods, such as an excise tax. Some social or compulsory insurance contributions are, in fact, a payroll tax collected by government. Here we distinguish between taxes, which are collected by government, and compulsory insurance contributions, which are normally collected by an independent or semi-independent agent. Taxes can be general or hypothecated – that is, earmarked for a specific area of expenditure”.²³

As for social health insurance, contributions for it “are usually related to income and shared between the employees and employers. Contributions may also be collected from self-employed people, for whom contributions are calculated based on declarations of income or profit (this income may be underdeclared in some countries). Contributions on behalf of elderly, unemployed or disabled people may be collected from designated pension, unemployment or sickness funds, respectively, or paid for from taxes. Social health insurance revenue is generally earmarked for health and collected by a separate fund”.²⁴

Private health insurance plays important role in health care financing, its main distinction from social health insurance is that it is provided by private companies and has voluntary

²² Elias Mossialos et al., 2

²³ Elias Mossialos et al. 2

²⁴ Elias Mossialos et al., 4-5

character. “Private health insurance premiums are paid by an individual, shared between the employees and the employer or paid wholly by the employer. Premiums can be: individually risk rated, based on an assessment of the probability of an individual requiring health care; community rated, based on an estimate of the risks across a geographically defined population; or group rated, based on an estimate of the risks across all employees in a single firm. The agents collecting private health insurance premiums can be independent private bodies, such as private for-profit insurance companies or private not-for-profit insurance companies and funds. Government may subsidize the cost of private health insurance using tax credits or tax relief”.²⁵ However, only private medical insurance can not guarantee universal access to health care and equity in health care provision. Because “the most important misalignment is the potential for sick people to suffer in a competitive medical-care system, since payments for them do not always cover their costs”.²⁶ And “a significant share of the population still sees medical care as a right, not a good. Social solidarity is a unifying factor in many countries, and the idea of using incentives to allocate medical care risks violating this solidarity”.²⁷

Some authors emphasize the necessity of separating health care budget from other spending. They argue that “separating health care from other areas of public spending could lead to other calls to have earmarked budgets and prevent the integrated health policy now being more widely recognized as the key to improving population health”.²⁸

Among other advantages of health insurance system is its ability of “implementation of two basic principles: efficiency and equity in health care providing. The efficiency of the health

²⁵ Elias Mossialos et al., 5

²⁶ David M. Cutler, “Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform”, *Journal of Economic Literature* Vol. XL (September 2002), 892, [http://www.jstor.org/sici?sici=0022-0515\(200209\)40%3A3%3C881%3AEEAMFT%3E2.0.CO%3B2-O&cookieSet=1](http://www.jstor.org/sici?sici=0022-0515(200209)40%3A3%3C881%3AEEAMFT%3E2.0.CO%3B2-O&cookieSet=1) (accessed May 10, 2008)

²⁷ David M. Cutler, 893

²⁸ Elias Mossialos et al., 16

insurance system depends on relationship between health insurance institutions and health care providers, in which way the obligations of both sides are precisely determined. Health insurance funds have a long-term interest to accept funding also for some services that will bring to additional total running expenditures (measures for prevention, early detection of the diseases, usage of adequate health technologies).²⁹ “On the other side, the policy for participation of the users in the expenditures for the received health services tends toward decreasing of total health expenditures through reduction of the excessive and unnecessary consumption of health services. As a rule the administrative costs are low, although in the systems that lack adequate personnel and technology those expenditures could be even higher than 20% of the total health care expenditure”.³⁰

“The equity is one of the basic principles of the health insurance by which the healthy people pay for the sick people, the young people for the elderly, and the rich people for the poor people. Everyone pays a contribution proportional to his economic situation, and use the health care according his needs”.³¹

Bjegović and Donev consider that “the critiques of the health insurance systems are directed toward determination of which groups of insured persons have more and which fewer privileges. This type of investigations in many developing countries have shown that insured persons in the urban environments use much more health care than those in the rural environments, first of all because of the higher accessibility of the health organizations and services to the population in the cities. According to some other investigations the poor social layers are in more favourable situation in spending health insurance funds because they become

29 Vesna Bjegović and Dončo Donev, ed., 316

30 Ibid., 316

31 Ibid., 316

ill more often and use the health care and services much more, even they contribute less in real quantity of sources”.³²

1.3 Different models of the medical insurance and health care financing

“Today’s health systems are modeled to varying degrees on one or more of a few basic designs that emerged and have been refined since the late 19th century”.³³ Bjegović and Donev distinguish three basic models of health care systems: private insurance model, Beveridge model and Bismark model which depend on the main source of their financing.³⁴ Here I would add a Soviet model of health care provision, investigating of which is very important for analyzing of the trends of health care of transitional countries.

I would start a consideration from a private insurance model, typical representative of which is the United States. In spite of the fact that pure private health insurance model is not predominant in transitional countries, it can be useful for analyzing the specificity of private insurance in these countries. “The “private” insurance model is also known as the model of ‘independent customer’. Funding of the system is based on premiums, paid into private insurance companies. In this system, the funding is predominantly private”.³⁵ This system is characterized with market competition among the providers. “Insurance market competition has been most prominent in the United States. While the United States never had a heavily regulated system, it did have a very generous system historically, with few constraints on either the demand or supply side”.³⁶

³² Vesna Bjegović and Dončo Donev, ed., 316

³³ Ibid., 24

³⁴ Ibid., 25

³⁵ Ibid., 26

³⁶ David M. Cutler, 882

Private insurance “involves many complicating features, both at the plan level and with respect to the costs that employers face. In particular, plans may cover both the worker (who supplies the productivity) and his family”.³⁷

A lot of authors stress that private insurance is designed for high income population and does not suit lower income groups and thus are mostly spread in developed countries while in developing patients usually pay directly. For example, Mechanic and Rochefort argue that “in middle-income countries and much of the developing world three systems of care are typical: a private system for the wealthy, who either acquire private insurance or purchase services directly; a government-funded social security insurance system that covers important government employees and other high priority occupational groups; and a resource-strained public sector for the vast majority of population”.³⁸ Cutler agrees with this saying that “no high- or middle-income country uses private coverage as a primary method for insuring population who are poor or at the high risk. Even in the United States, which has the largest private insurance market in the world, poor people and elderly people are covered through large, publicly funded programmes”.³⁹ Because, he continues, “the most important misalignment is the potential for sick people to suffer in a competitive medical-care system, since payments for them do not always cover their costs”.⁴⁰

In Europe two main models are widely spread. “In the Beveridge “public” model funding is based mainly on taxation and is characterized by a centrally organized National Health Service

³⁷ Matthew S.Dey and Christopher J.Flinn, “An equilibrium model of health insurance provision and wage determination”, *Econometrica*, Vol.73, no. 2, March, 2005, 575 <http://www.blackwell-synergy.com/action/showPdf?submitPDF=Full+Text+PDF+%28485+KB%29&doi=10.1111%2Fj.1468-0262.2005.00588.x&cookieSet=1> (accessed May, 10, 2008)

³⁸ David Mechanic and David A. Rochefort, “Comparative Medical Systems”, *Annual Review of Sociology*, Vol. 22, (1996), 243, <http://www.jstor.org/stable/2083431> (accessed May 12, 2008)

³⁹ Neelam Sekhri and William Savedoff, “Private health insurance: implication for developing countries”, *Buletin of World Health Organization* 83, no. 2 (2005), 132, <http://www.who.int/bulletin/volumes/83/2/en/127arabic.pdf> (accessed May, 10, 2008)

⁴⁰ David M. Cutler, 892

where the services are provided by mainly public health providers (hospitals, community GPs, specialists and public health services). In this model, healthcare budgets compete with other spending priorities. The countries using this model, beside United Kingdom, are Ireland, Sweden, Norway, Finland, Denmark, Spain, Portugal, Italy, Greece, Canada and Australia”.⁴¹

“In the Bismarck „mixed” model funds are provided mainly by premium-financed social/mandatory insurance and, beside Germany, is found in countries such as Holland, Belgium, France, Austria, Switzerland, Israel, Japan, Central and South East European (CSEE) countries and Former Soviet Union (FSU) countries. Also Japan has a premium-based mandatory insurance funds system. This model results in a mix of private and public providers, and allows more flexible spending on healthcare”.⁴² Private insurance is used as additional source for financing in a form of complementary and supplementary health insurance. “Complementary voluntary health insurance provides cover for services excluded or not fully covered by the state, particularly cover for statutory user charges, as in Croatia, Denmark, France and Slovenia. Supplementary voluntary health insurance provides cover for faster access and increased consumer choice and is available in most EU member states”.⁴³

The model of social health insurance is able to seize the majority of the population. For example in Germany “statutory health insurance system (GKV), which was set up under the Federal Government’s social legislation scheme, provides insurance protection for about 90% of Germany’s citizens since GKV membership is obligatory for employees up to a fixed income level”.⁴⁴

⁴¹ Vesna Bjegović and Dončo Donev, ed., 25

⁴² Ibid., 26

⁴³ Sarah Thomson and Elias Mossialos, “Private health insurance and access to health care in the European Union”, *Euro Observer*, Vol. 6, No. 1 (2004), 24, <http://lse.ac.uk/collections/europeanInstitute/articles/mossialos1.pdf> (accessed May 14, 2008)

⁴⁴ Vesna Bjegović and Dončo Donev, ed., 26

“The collection agent in this model can be a single national health insurance fund (such as in Croatia, Estonia, Hungary and Slovakia) or a single social insurance fund (Belgium). The collection function may be devolved to independent funds (France), local branches of a national fund (Romania), individual health insurance funds, either occupationally or geographically defined (Austria, Czech Republic, Germany, Lithuania and Switzerland), or an association of insurance funds (Luxembourg)”.⁴⁵ Mainly this model is based on the contribution “shared between the employees and employers”.⁴⁶ However, “contributions may also be collected from self-employed people. Contributions on behalf of elderly, unemployed or disabled people may be collected from designated pension, unemployment or sickness funds, respectively, or paid for from taxes”.⁴⁷

These two models have different priorities from the point of view of quality and costs. “A government-run national health service (the Beveridge model) can provide care for all at the reasonable cost but can not avoid the dangers of poor quality. An insurance-based system (the Bismarck model) can achieve high quality but can not ensure care for all at the affordable cost”.⁴⁸ In favour of social insurance financing of health services Cichon and Normand mention such aspects as earmarking of resources for health, which tend to be a more stable source of funds, self-governance, defined entitlements.⁴⁹ Among its weaknesses: high labour costs, administrative complexity, problems in cost control.⁵⁰

⁴⁵ Elias Mossialos et al., ed., 17

⁴⁶ Vesna Bjegović and Dončo Donev, ed., 315

⁴⁷ Ibid., 315

⁴⁸ Michael Cichon and Charles Normand, “Between Beveridge and Bismarck – option for health care financing in Central and Eastern Europe”, *World Health Forum*, Vol,15, 1994, 323
[http://whqlibdoc.who.int/whf/1994/vol15-no4/WHF_1994_15\(4\)_p323-328.pdf](http://whqlibdoc.who.int/whf/1994/vol15-no4/WHF_1994_15(4)_p323-328.pdf) (accessed May 15, 2008)

⁴⁹ Ibid., 324

⁵⁰ Ibid, 326

Socialist health system, so called Semashko model “was provided by state institutions on the guiding principle of free universal entitlement at the time and point of service. The system was financed by payroll taxes while the central budget offered significant additional funds on behalf of those who did not have income from a permanent job”.⁵¹ However the system became universal not at once. “The majority of Central and Eastern European countries declared universal access only from 1972 onwards”.⁵² “Health care was considered to be based on the concept of social insurance (wrongly translated as social security) which, in turn, was claimed to represent societal solidarity”.⁵³ “Health care was officially paid for through the state budget. Formally, resources for health care were included as a share of the social insurance contribution made by enterprises on the basis of wages, but these contributions were not officially linked with expenditures on health care. Rather, funds were collected by the state, which then made budget allocations to health care and other sectors. In this sense, the system was not "contributory" by beneficiaries”.⁵⁴

As for the advantages of this system Bjegović and Donev mention providing equal conditions in health care consumption for all citizens, independently of the social status and economic power, the place of living and working.⁵⁵ The weaknesses of this system in their opinion are that it “has insufficient creativity in the process of improving of efficiency and quality of the health care, as well as the fact that the taxpayers from whom the sources are taken,

⁵¹ Lajos Bokros, “Health Care Reforms in Central and Eastern Europe” in Recent Economic Reform Experience from Central Europe: Inspirations and Suggestions for Ukraine, (Kyiv: ICPS, 2005), 11, www.pasos.org/content/download/23436/110722/file/INEKO_Reform_Experience_CE_ENG.pdf (accessed May, 15, 2008)

⁵² Peter Mihalyi, 34

⁵³ Lajos Bokros, 11

⁵⁴ Peter Berman, “National Health Insurance in Poland: A Coach without Horses?”, Harvard School of Public Health, 1998, 2, <http://www.hsph.harvard.edu/ihs/publications/pdf/No-63.PDF> (accessed May 15, 2008)

⁵⁵ Vesna Bjegović and Dončo Donev, ed., 315

have no influence in their use”.⁵⁶ Among other shortcomings Lajos Bokros notes constant and serious imbalance between demand and supply, no link between contributions and benefits.⁵⁷ Besides, “as in tax-financed systems, health competed with other areas of public spending and expenditure on health was the outcome of political negotiations. Here, the health sector was seen as unproductive and was not well favoured”.⁵⁸ The transitional countries inherited some contradictions of Soviet model of health financing. And particularly this has something to do with the merge of purchaser and provide sides and informal payments. “In communist economies the purchaser-provider split existed only on paper, if at all. There was never any close link between social insurance revenue on the one hand and healthcare expenditures on the other. Both types of the financial flows were determined by administrative fiat and the resultant deficits or surpluses were simply absorbed by the central budget. The social insurance institutions were quasi-governmental institutions”.⁵⁹ As the system was overregulated and inflexible a solution in form of informal payments of the patients for additional or privileged services was found. “The solution took the form of illegal payments (bribes known as “gratitude money” or “under-the table payments)”.⁶⁰ This left a significant trace on the transitional countries’ performance as this practice is widely spread now in the countries of Central Europe and comprises the basis for health care financing in the countries of former Soviet Union.

Many authors such as Bjegović and Donev also note the inability of health care schemes of the Soviet system to satisfy the current needs of the population of CEE countries which made

⁵⁶ Vesna Bjegović and Dončo Donev, ed., 315

⁵⁷ Lajos Bokros, 11

⁵⁸ Sara Thomson et al., “ISS Statistics: Health and Health Systems in the New Member States”, (Paris: Institute des Science de la Sante, 2004), 16-17,

<http://www.who.org/IMG/pdf/report.pdf> (accessed May 15, 2008)

⁵⁹ Peter Mihalyi, 34

⁶⁰ Ibid., 35

these countries search for alternative models of health care financing.⁶¹ In my opinion the most appropriate transition for CEE countries from the Soviet model of health care financing is social insurance scheme, because it preserves near universal provision of the population at the acceptable costs. This was proved by the fact that CEE countries have chosen this way of development of their health care systems. As for Beveridge “public” model of funding, in my opinion it is more appropriate for developed Western countries, which have sufficient budget sources to cover the health care. Health care insurance is an attribute and index of the development of country, in less developed countries the health care is financed via direct payments. Social health insurance can not be a single source for financing health care and should be supplemented with other types of insurance and state’s support of vulnerable groups of population.

⁶¹ Vesna Bjegović and Dončo Donev, ed., 316

Chapter 2: The problem of providing medical insurance in transitional countries

The general trends in the development of transitional countries concerning the health insurance reform in the health can be marked out. First of all it is movement to social insurance schemes and separation of spendings for health insurance into independent health insurance fund. This tendency is most distinctly expressed in Central European countries followed by some countries of former Soviet Union, for example Russia. The case of the later presents very interesting example for Ukraine due to geographical closeness and similarities in economic development.

2.1 The direction and speed of health insurance reforms in transitional countries

“Before the transition to a market economy, the health systems of Central and Eastern European countries shared comparable roots, similar characteristics, with common strengths and weaknesses”.⁶² “During the period of political and economic transition following the break-up of the Soviet bloc, health systems in the CEE countries underwent extensive financing and organizational reforms. In most cases the reforms aimed to move away from the centralized and integrated state model known as the Semashko system to the decentralized model of social health insurance”.⁶³ The reason for transforming health care systems was inefficient functioning of the system, sufficient lack of financial recourses and incompatibility of the old system to new marketing trends in economy. However it must be noted that Central European countries in contrast to the countries of former Soviet Union had a different legacy before World War II and

⁶² Formal and informal household spending on health: a multicountry study in Central and Eastern Europe, (Harvard School of Public Health, 2002), 7, <http://www.hsph.harvard.edu/ihs/publications/pdf/lac/MerckReportFINAL.pdf> (accessed May 16, 2008)

⁶³ Sara Thomson et al., 1

their health care systems contained certain characteristics of social health insurance. Probably, that is why the transition to a social insurance system happened more quickly and had more well-ordered character in these countries of FSU.

“In the transition of the early 1990s two new sources of funding emerged in CEE health systems: social health insurance contributions, usually in the form of earmarked payroll taxes, and out-of-pocket payments, both official user charges and informal payments”.⁶⁴ But “the major source of central government’s health funding was mandated social insurance contributions.”⁶⁵

Another trend was expressed in moving from a centralized system of revenue collection to the decentralized system. “In many countries, decentralization led to the devolution of revenue collection to regional governments or regional health insurance funds, which gave rise to difficulties in enforcing collection and inequities between regions. Some re-allocation mechanisms have been designed to ensure redistribution according to the health needs of the populations covered”.⁶⁶ The solution for this unequal redistribution was organization of some equalization funds. For example, “In Poland an Equalisation Fund is used to redistribute across insurance funds on the basis of age and average income”.⁶⁷

The purpose of reforms was to separate financing and provider sides. “In principle the new agencies, entrusted with the role of purchasers of services vis-à-vis providers of services, should have added pressure and incentives for cost-containment, efficiency and/or quality enhancement through contractual specification of mutual responsibilities with providers and promoting competition among providers”.⁶⁸

⁶⁴ Sara Thomson et al., 17
<http://www.eph.org/IMG/pdf/report.pdf> (accessed May 15, 2008)

⁶⁵ Formal and informal household spending on health: a multicountry study in Central and Eastern Europe, ed. Paolo Belli, 16

⁶⁶ Sara Thomson et al., 27

⁶⁷ Ibid., 27

⁶⁸ Paolo Belli, 16

“While the specific elements differ across countries, some type of national health insurance based largely on a Bismarckian model is widely perceived by national authorities as the best structural solution to common problems”.⁶⁹ However it can be argued that in transitional countries this model did not completely resembled Bismarckian model, as “in reality much less happened. Where it existed before, the staterun social insurance was extended. Where such institutions didn’t exist at all, a sizeable part of the health ministry was carved out and a new government body was called into being.”⁷⁰ And “the newly created system differs from the Bismarckian model in three fundamental ways. First, there is only one fund and not dozens, or hundreds from which people can choose on their will. Second, membership in this staterun fund is mandatory for the entire population. Third, the use of the health care services at the point of delivery is free of charge, unlike most Bismarckian systems, where fees and drug expensive are first paid, then reimbursed”.⁷¹

The directions speed of the reforms in transitional countries differed in the details. “The health system in the Czech Republic has undergone several changes and reforms, some of which are still ongoing”.⁷² “Since 1991 the health care system has moved towards a compulsory health insurance model, with a number of insurers financing health care providers on the basis of contracts”.⁷³ “Privatization of financing began simultaneously in 1994. By the end of 1994, in addition to the state-owned General Health Insurance Office, there were 18 competing private insurance companies. Enrollment in insurance was mandatory. Funds are raised through a combination of a wage-based tax (13.5%) split 2:1 between employer and employee and state or

⁶⁹ Peter Berman, 16

⁷⁰ Peter Mihalyi, 46

⁷¹ Ibid., 46

⁷² Vesna Bjegović and Dončo Donev, ed., 196

⁷³ M. Rokosová, P. Háva, J. Schreyögg, and R. Busse., *Health care systems in transition: Czech Republic*. (Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005), 13, <http://www.euro.who.int/document/e86823.pdf> (accessed May 16, 2008)

individual contributions for certain groups”.⁷⁴ “The united Czechoslovakia was the first country, where competing for-profit insurance funds were created right from the outset and these funds were allowed to compete with each other.”⁷⁵ “For the Czech Republic, the shift towards managed care and market incentives means facing the past as well as the future. The changes in financing, regulation, and functional integration that move the system in the direction of US style managed care, also bear a resemblance to the former state socialist health care system. This raises some dilemmas for the new market democracy”.⁷⁶

“Hungary created a single payer social health insurance system in 1989, but only separated health financing from pension financing in 1992 with the establishment of a national Health Insurance Fund”.⁷⁷ “The revenue of the HIF is derived mainly from the health insurance contribution, a proportional payroll tax, paid partly by the employers and partly by the employees. The other revenue source of the HIF is the so-called “hypothecated health care tax”, consisting of two components: a lump sum tax and a proportional tax. The latter is levied only on those types of income which are not subject to social insurance contribution”.⁷⁸ “The health insurance contribution is proportional. It is determined by the National Assembly and for group 1 it is split between employer and employee. In 2002 the health insurance contribution was 14% of the gross salary: employers paid 11% and employees had to pay 3%, deducted directly from the gross salary”.⁷⁹ “National and local taxes as well as private sources complement social health insurance in health care financing. Private sources are almost exclusively out-of-pocket

⁷⁴ Peter Berman, 16

⁷⁵ Peter Mihalyi, 47

⁷⁶ Krizova, Eva, Simek Juri (Ed.). *Health Care Reforms in Central and Eastern Europe. Outcomes and Challenges*, (Prague: Charles University, 2000), 51-52

⁷⁷ Peter Berman, 17

⁷⁸ Gaál P, *Health care systems in transition: Hungary*, (Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004), 33,
<http://www.euro.who.int/Document/E84926.pdf> (accessed May, 15, 2008)

⁷⁹ *Ibid.*, 37

payments to cover co-payment, or to utilize private health care services, since private health insurance has not yet taken root in the system”.⁸⁰ “Out-of-pocket payments in the Hungarian health care system are discernible in three main forms. First, some products and services are not covered by social health insurance and are financed out-of-pocket. Second, patients make co-payments for services and products which are partly covered by the HIF. Third, patients pay medical doctors and non-medical health professionals informally for services covered by the HIF”.⁸¹

“In 1997 Poland passed legislation to establish a new national health insurance scheme, had to take effect from January 1, 1999”.⁸² “The general health insurance in Poland was proposed to be funded by a transfer from tax revenues without any contribution from the beneficiary, even though there existed substantial evidence of individual ability and willingness to pay for health care. Recognizing the current levels of private spending, policy-makers in Poland could thus make a case for raising additional revenues from households, if they can successfully replace out-of-pocket spending with insurance benefits”.⁸³ “The aims of the new insurance scheme were to tap new sources of revenue, formalize health sector financing, further decentralize the administration of health care services, and introduce market mechanisms in order to increase efficiency”.⁸⁴ Poland was a late-comer for a health care reform and the introduction of social health insurance. However it is argued by several authors that due to this fact reforms in Poland were more organized and better thought-out. For example as it was stated by Berman, “simply developing a market friendly environment for health care or even a more

⁸⁰ Gaál P, 41

⁸¹ Ibid., 44

⁸² Mukesh Chawla, Peter Berman, Dorota Kawiorska, Financing Health Services in Poland: New Evidence on Private Expenditures, (Harvard School of Public Health, 2004), 12, <http://www.hsph.harvard.edu/ihs/publications/pdf/No-65.PDF> (accessed May 15, 2008)

⁸³ Ibid.,12

⁸⁴ K. Kuszewski, C. Gericke. “Health Systems in Transition: Poland”, *European Observatory on Health Systems and Policies*, Vol.7, No.5, 2005, 23, <http://www.euro.who.int/Document/E88670.pdf> (accessed May 14, 2008)

directed approach of managed financial incentives may not be sufficient to create an efficient, equitable, and sustainable health care system under current Polish conditions”.⁸⁵

“In Slovakia a multipillar financing also was introduced offered by strong private institutions defending the interest of patients while competing for their money”.⁸⁶ “However there exists a mix of public and private sources funds health care in Slovakia. Public expenditure on health includes spending from the national budget and contributions to the statutory health insurance”.⁸⁷ “The major health reforms started in 2004 with adoption of legislation introducing private market principles in health care and financing. Privatization of out-patient care and health insurance funds had on one hand led to fiscal discipline and decreasing indebtedness of health sector, on the other increased inequalities in access and quality of provided care”.⁸⁸ “To sustain health care expenditures, Ministry of Health has to work out basic benefit package (BBP) and introduce supplementary/voluntary health insurance. Discussions are ongoing whether to create only one public health insurance company instead of five, four of them being private, but managing public funds. Financial protection must be improved as the private household expenditures reached the impoverishing level in more than 20% of population”.⁸⁹

The Russian case is very significant for the evaluation of introduction of social health insurance in transitional country and particularly for Ukraine. “In light of its size and diversity, Russia opted for a regionalized financing system under national health insurance. Resource mobilization is delegated to the regions, based on an earmarked payroll tax. Provision is made

⁸⁵ Peter Berman, 1

⁸⁶ Lajos Bokros, 11

⁸⁷ S. Hlavačka, et al.. *Health care systems in transition: Slovakia.* (Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004), 33, <http://www.euro.who.int/Document/E85396.pdf> (accessed May 11, 2008)

⁸⁸WHO, “Country cooperation strategy at a glance”, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_slovakia_en.pdf (accessed May 17, 2008)

⁸⁹ WHO, “Country cooperation strategy at a glance”, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_slovakia_en.pdf (accessed May 17, 2008)

for contributions to a central fund for redistribution and equalization. Within the regions, both public and private insurance funds will compete for enrollees, receiving a risk-based capitation premium for each enrollee from the regional funds. It is intended that provider payment will employ a variety of methods”.⁹⁰ In Russia system of medical insurance was designed as compulsory system which “presented itself as the solution”⁹¹ to insufficient financing the health care.

Reformers followed the objectives of preserving general enrollment of the population into health coverage and objectives of market efficiency in the health care. “Key objectives of the legislation were to provide new sources of non-budget financing in order to augment the existing budgetary sources, to provide a mechanism for the pooling of all funds, and to continue to provide universal access and comprehensive coverage for the population while introducing patient freedom of choice of provider and insurer”.⁹²

“Implementation of the health care reform legislation began in 1993 with the establishment of the federal mandatory fund and territorial health insurance funds, which began to collect insurance contributions. By the start of 1994, 79 regional funds and 587 of their branches, as well as 164 insurance companies had been established. By the late 1990s there were 89 territorial funds (one in each subject of the Federation), 1170 branches of territorial funds, and 415 insurance companies”.⁹³

Wage-based social insurance contributions paid by employers were fixed in the following way: “0.2% of the wage bill is paid to the federal fund for equalization purposes, and 3.4% of the

⁹⁰ Peter Berman, 18

⁹¹ Ellie Tragakes, and Suszy Lessof, “Health care systems in transition: Russian Federation”, *European Observatory on Health Systems and Policies*, 5(3), (2003), 71 <http://www.euro.who.int/document/e81966.pdf> (accessed May 17, 2008)

⁹² Ibid., 71

⁹³ Ibid., 76

wage bill to the territorial funds. In addition, employers may decide to purchase voluntary health insurance for their employees that was subsidized by the government through tax relief”.⁹⁴ As the system was aimed at preserving of general inclusion of the whole society as it was in Soviet health care system state provided additional subsidies for non-working population. “In addition to contributions to benefit working people, municipal governments are to make payments to the Fund on behalf of children, pensioners, housewives and the unemployed, at the per-person rate agreed at the oblast’ level but not below the average regional contribution employers make for each worker.”⁹⁵ The positive side of the reform was seen in the fact that “the medical insurance Funds are isolated from the unpredictable vagaries of formation and implementation of the government budget”.⁹⁶

So as it can be seen from the empirical evidence the majority of countries of Central Europe and some countries of FSU opted for general mandatory health insurance schemes. However the details of these social insurance schemes differ in a level of admitted competition in the system, the amount of contributions and year of introduction of the system. The particular features of the implemented social insurance schemes can be summarized in the Table 1:

⁹⁴ Ellie Tragakes, and Suszy Lessof, 74

⁹⁵ Judyth L. Twigg, “Balancing the State and the Market: Russia's Adoption of Obligatory Medical Insurance”, *Europe-Asia Studies*, Vol. 50, No. 4, (Jun., 1998), 7, <http://www.jstor.org/stable/153778> (accessed May, 17, 2008)

⁹⁶ *Ibid.*, 7

Table 1. The features of the social health insurance in chosen transitional countries:

Country	Year of the first wave of reforms	Contribution in % from wage	The ratio of employer /employee contribution	Budget pays for non-working population	Co-payments	State-run fund	Regional funds	Private funds
Poland	1999	9%	n/a	yes	legal + illegal significant	only	Initially yes but later merged	Planned only
Hungary	1991	14%	3/1	yes	legal + illegal significant	only	no	Were planned in 2008
Czech Republic	1992	13,5%	2/1	yes	insignificant	State + non profit funds	no	Planned from 2009
Slovakia	1992	14%	2/1	yes	insignificant	State + for profit funds	no	Since 2004
Croatia	1993	16%	1/1	yes	insignificant	only	no	no
Bulgaria	1999	6%	1/1	yes	legal + illegal significant	only	no	Planned from 2009
Russia	1993	3,4%	1/0	yes	legal + illegal significant	State + for profit funds	yes	yes

Source: European Observatory on Health Systems and Policies

So in the majority of CEE region countries' "public health funding predominantly consists of payroll tax contributions".⁹⁷ No country opted for the system where government budget sources were completely excluded from the health care financing. In spite of general mandatory entitlement which allows no opt-out for the population and almost general coverage, out-of-pocket payments are still widely spread. And they are mostly spread in those countries where private health insurance does not play great role in health care financing. The contribution rates are set extremely low in Russia and Bulgaria comparably to other countries that allows to

⁹⁷ Paolo Belli, 41

make assumption that only countries with relatively stable economic development can set contribution to health insurance fund at a high level.

2.2 Outcomes of reforms and problems in health insurance sector in transitional countries

During the period of introduction of a new system transitional countries faced significant problems that can be explained by a difficulty of transitional period itself and by the imperfection of the model they tried to implement. “The macro evidence available suggests that the above reforms did not lead to significant improvements in health systems' effectiveness and accessibility, with very few exceptions concentrated mainly in CEE countries”.⁹⁸ As Thomson, Mossialos, McKee, Nolte and Allin argue that while “the reform efforts of the last decade represent a genuine attempt to improve health and health systems in the CEE region, there is evidence to suggest that the shift to a social health insurance model and changes in provider payment mechanisms have not been sufficient to ensure substantial gains in health system performance”.⁹⁹ The reason for this they see in that fact that “liberalization of the region at the start of the transition period was followed by steep economic declines, which eroded governments' financial stability and thus limited financial investments in health”.¹⁰⁰ “Another reason for this was that fact that the movement towards a social health insurance model of health financing may have been inappropriate, given the labour market and employment characteristics of the region”.¹⁰¹ That is connected with higher degree of unofficial employment and tax evasion in transitional countries in contrast to Western European countries.

⁹⁸ Paolo Belli, 30

⁹⁹ Sara Thomson et al., 4

¹⁰⁰ Sara Thomson et al., 4

¹⁰¹ Sara Thomson et al., 4

Transitional countries also have faced with some market imperfections in the healthcare. “Market mechanisms in health care are likely to be more successful, financially and operationally, if they are focused on hospitals and physicians; in contrast, efforts to create competition among multiple private insurers or to require increased co-payments from patients have been notably less successful”.¹⁰² The socialist heritage of state predominance also influence the successfulness of the reforms and is particularly expressed in fact that “in many CEE countries the collection and allocation of revenues still occurs in a centralized fashion rather than through multiple health insurance funds”.¹⁰³

In my opinion the incentive of evasion of social insurance schemes is increased with the highest degree of contribution, however this statement is required further investigation. But at the moment it can be stated that this evasion embarrass the collection of social contribution for health insurance funds. In particular Bjegović and Donev state that “if social insurance is not mandatory for the entire working population, it can create a perverse incentive for employers. Thus, they may offer part-time jobs that pay below the minimum threshold, outsource employment so that contractors are self-employed or create jobs in the shadow or unofficial sector”.¹⁰⁴ They also emphasize that “these practices are common in CEE and FSU countries with newly established social health insurance schemes: employers, faced with an adverse economic climate, have tried to minimize labor costs by evading contributions to social health insurance”.¹⁰⁵

Also it can be argued that only one social insurance as a source for funding health care is unable to cover all the costs. “The new social insurance or sickness funds achieved mixed

¹⁰² Vesna Bjegović and Dončo Donev, ed., 312

¹⁰³ Sara Thomson et al., 27

¹⁰⁴ Vesna Bjegović and Dončo Donev, ed., 317

¹⁰⁵ Ibid., 317

results. On the one hand, they contributed to build new institutional capacity in the public sector, and some of the more promising reform initiatives were channeled and promoted through their apparatus. On the other hand, the necessity to strengthen them diverted resources from other urgent programs during a period of extremely tight”.¹⁰⁶

Formal and informal out-of-pocket payments constitute another difficulty for operation of new social health care system. Poland is a good case for considering the reasons for out-of-pocket payments. “In terms of overall health system performance, the high out-of-pocket spending in Poland probably reflects three important trends. First, while during the 1960s, '70s and early '80s, Poland achieved substantial health care coverage and improvement in health status via a socially financed national health service, during the 1980s this system began a substantial decline. Economic decline produced fiscal pressures forcing lower public spending on health. Second, and simultaneously, an aging population and rising expectations, particularly after the transition to a market-based economy, increased demand for health care. Third, while such pressures were not unfamiliar in other European countries, Poland was unable to mount a successful organized response to them, either via new resource mobilization or by sensible cost containment”.¹⁰⁷ This practice of informal payments was inherited from the Soviet time and acquired deep roots in transitional societies.

The significant spread of out-of-pocket payments interferes the development of private insurance incentives in transitional countries. “Private health insurance remains small in most countries and does not contribute significantly to health care expenditure, despite hopes that such

¹⁰⁶ Paolo Belli, 31

¹⁰⁷ Mukesh Chawla, Peter Berman, Dorota Kawiorska, 11

coverage would develop as a supplementary source of revenue. This may in part be attributed to the widespread use of informal payments in the region”.¹⁰⁸

The success or failure of new health insurance system depends on many factors. But the most significant in my opinion is a general economic development of the state. As it was argued by Thomson, Mossialos, McKee, Nolte and Allin, “it is not surprising that the countries that have been more successful in making the transition to social health insurance contributions (where such contributions account for more than 60% of total health expenditure) are also those with the highest levels of per capita GDP (Slovenia, the Czech Republic, Hungary and Slovakia)”.¹⁰⁹

The level of bureaucracy and corruption also influence the ability of social insurance to work. For instance in Poland “since collections will continue to be done through the same state apparatus that now collects taxes, and since direct state subsidies to insurance funds are still envisaged, it is unlikely that this system will raise less money for health care, than the current state financing system. Revenue sources will be more clearly identified and the state will still be available to assure at least historically comparable levels of financing”.¹¹⁰

The cost escalation can be noticed in some countries after the introduction of social health insurance schemes. For example in Czech Republic “cost escalation was rapid, bringing the Czech Republic’s health spending from 6.5% of GDP in 1991 to 9.5% of GDP in 1995. The state was forced to subsidize rising expenditures and several private insurers went bankrupt”.¹¹¹ Thus as it can be clearly seen on Czech example there is a need “to pay close attention to the

¹⁰⁸ Sara Thomson et al., 3-4

¹⁰⁹ Ibid., 25

¹¹⁰ Peter Berman, Andrzej Rys, Marc Roberts, Paul Campbell, “Notes on Health Sector Reform in Poland”, (Harvard School of Public Health, 1998), 2, <http://www.yourhealthrisk.harvard.edu/ihsg/publications/pdf/No-62.PDF> (accessed May 17, 2008)

¹¹¹ Ibid., 3

details in health care delivery which can provide incentives for cost control throughout the multi-layered health system”.¹¹²

Reforms in Russia present the most difficult case from the point of view of how to make work the system that was created on the papers and in legal sphere. As it was noted by Barr and Field, “the Russian reform plan has encountered severe problems and seems to lack widespread support. While the plan was initially enacted in January 1993, funding for it did not become available until November of that year. Of the funds collected through a 3.6% employment tax on businesses, one third has been lost through inflation and an additional 29% was diverted into loosely controlled investment accounts; this left only about 40% of funds available to pay for direct medical services. As a result, health care in Russia continues to be woefully underfunded, and many of the more affluent are turning to an increasing array of private health services, available only through cash payment”.¹¹³

Another dangerous trend is the lack of controlling of the system. “If health care in Russia and the other newly independent states is left to private practice and private medical insurance without consideration for cost, access, or quality, existing disparities in the quality and availability of health care services will widen. This is exactly what has already happened in the Czech Republic”.¹¹⁴

Tax evasion and a great extent of shadow economy that prevails in Russia even more than in Central European countries makes collection of funds very difficult and threaten the existence of the whole system. “In countries such as Kazakstan, Kyrgystan, Russia, Bulgaria and the Slovak Republic, a combination of falling total employment and shrinking tax revenue are

¹¹² Peter Berman, Andrzej Rys, Marc Roberts, Paul Campbell, 3

¹¹³ Donald A. Barr and Mark G. Field, “The Current State of Health Care in the Former Soviet Union: Implications for Health Care Policy and Reform”, *American Journal of Public Health*, March, 1996, vol.86, No.3, 307, <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1380507&blobtype=pdf> (accessed May 17, 2008)

¹¹⁴ *Ibid.*, 4

hindering attempts to use employment-based coverage as a basis for national health insurance”.¹¹⁵ Another problem is exclusion of those working in unofficial sector meaning “that the validity of social insurance is based on the ability to make payroll deductions, which tends to exclude those working in the informal economy”.¹¹⁶

Another problem of introduction of social health insurance in Russia was that “the financing and purchasing mechanism envisaged by the law has not yet been fully implemented in any of the regions, with the possible exception of Samara”.¹¹⁷ As for the remaining components, “they show a combination of old and new financing elements, with enormous regional variations in the pace of transition and relative success of implementation”.¹¹⁸ “In most of the regions budget financing co-exists with insurance financing. For example, in some areas the budget pays for all outpatient care while insurance pays for all inpatient care; in others insurance covers only inpatient care for adults; in still others insurance pays for the working population while the budget pays for all non-working people”.¹¹⁹

Shishkin summarizes the most contradictory points in Russian early health reform: “The reform, however, was hindered by the complexity of the proposed mandatory health insurance system, its incomplete implementation, eclectic combination of old and new financial arrangements, wide cross-regional variations in transitional models, poor coordination of actions and delineation of authorities between players in the field of health care finance, and failure to

¹¹⁵ Sara Bennet, Andrew Creese, Roeland Monasch, *Health insurance schemes for people outside formal sector employment*, (Geneva : World Health Organization, 1998), 5, http://whqlibdoc.who.int/hq/1998/WHO_ARA_CC_98.1.pdf (accessed May, 17, 2008)

¹¹⁶ Carl Afford, “Health systems in Eastern Europe – the impact of reform”, *New solutions*, Vol.14(1), 61 <http://baywood.metapress.com/app/home/content.asp?referrer=contribution&format=3&page=1&pagecount=18> (accessed May 17, 2008)

¹¹⁷ Ellie Tragakes,. and Suszy Lessof, 77

¹¹⁸ Ibid, 77

¹¹⁹ Ibid, 79

induce due competition between health insurance carriers”.¹²⁰ “As a result, territorial mandatory health insurance funds and insurance companies were practically unable to finance extra-territorial services and purchase a complete range of medical services defined in the mandatory health insurance program for their populations they serve”.¹²¹

The difficulties and the speed of providing health insurance can also be connected with the size and diversity of the population in particular country. As it was noted by Berman, “both Hungary and the Czech Republic are much smaller countries than Poland in physical size and population, making the rapid implementation of NHI easier, whereas Russia is of course much larger and diverse, compounding the difficulties”.¹²²

Nevertheless Russian health care reform and introduction of social health insurance had a lot of positive sides. Shishkin emphasize that at the same time, “some Russian insurers have demonstrated examples of institutional innovations to facilitate effective utilization of mandatory health insurance resources”.¹²³ “Insurance-based financing of the health care system has begun to stabilize, and even to rise in some regions. Some regions and insurers are beginning to understand the importance of prospective, efficiency-based incentive payment schemes, and in even more areas intensive work is being done on sophisticated quality measurement and control techniques”.¹²⁴ “The switch to obligatory medical insurance in Russia did indeed provide additional revenue for health care, although not as much as expected.”¹²⁵

Thus all transitional countries faced the problems while transforming their health systems from tax-based to insurance based. Tax evasion of the contributors to health insurance funds and

¹²⁰ Sergey Shishkin, “Problems of Transition from Tax-Based System of Health Care Finance to Mandatory Health Insurance Model in Russia”, *CMJ-online*, Vol. 40, Number 2, March (1999), 1, <http://www.cmj.hr/1999/40/2/10234062.htm> (accessed May 17, 2008)

¹²¹ Sergey Shishkin, 1

¹²² Peter Berman, 16

¹²³ Sergey Shishkin, 1

¹²⁴ Judyth L. Twigg, 17

¹²⁵ *Ibid.*, 9

unofficial payments decrease the efficiency of social health insurance system. The countries of Central Europe were more successful in implementing health insurance reforms than the countries of former Soviet Union that can be referred to their better economic development.

Chapter 3: Ukraine: the necessity of reformation of health care system in the light of changes in Central European countries

Ukraine is one of those countries of former Soviet Union where health care system remains unreformed. In spite of the changes in general trends of development towards market economy health care legally operates on the same basis of state owned and tax-based system. Resources that are allocated to medicine from tax are crucially insufficient to provide population even with basic medical services and to pay medical workers. Due to the severe dysfunctionality of the health care system market itself finds a solution in the form of informal out-of-pocket payments of the population directly to the medical staff. This remains a lot of people outside the accessibility of the health care and leaving a lot of financial funds unregulated.

There is a huge debate in Ukrainian society about the necessity of reformation of the system. The system that is most frequently proposed is the system of medical compulsory insurance. However the thoughts regarding the forms of this social insurance and time of its introduction are split. And the drafts on social insurance have been considered in Verchovnaya Rada for more than 10 years from 1998 up to now without any practical implementation. As it was said by the present deputy of Minister of Health Care of Ukraine Yakovenko, “even though that 11 drafts were prepared, there has not been any practical results so far. The reason of such inefficiency is in absence of common perception of this question for power and society. Hence the system of mandatory medical insurance is going to affect everybody”.¹²⁶

3.1 Current state of the health care system in Ukraine

¹²⁶ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

During the years of independence Ukrainian system of health care experienced no reforms and now it is the same system that operated in Soviet Union with an exception of severe lack of financing. “Unlike many other areas of the economy, health care financing in Ukraine as essentially retained the Soviet tax-based approach, providing universal and theoretically free coverage. Officially the provision of free services in state-owned health facilities is guaranteed by the Constitution of 1996”.¹²⁷ “Government budgets therefore remain the major official source for health care finance, with some 80% based on local budgets and the remaining 20% on the state budget, respectively supervised by the regional authorities and the Ministry of Health”.¹²⁸ The remaining Soviet model, even if it was efficient in general coverage of the population, in new conditions of transitional period is not able to provide the population even with basic medical care. “The post-independence economic crisis led to a significant fall in state income, which also had a substantial impact on health care funding. Although the actual share of the health care budget is about the same now as it was at the time of independence – at about 3% of the GDP – the sharp decline in GDP has meant a drop of over 60% in real-level health expenditures”.¹²⁹ “The need of national health care system in financing is approximately 8-10 billions hryvna per year that is commensurable to a level of health care financing in 1980. In a budget of 1998 funds are provided for within the limit of 3 billions of hryvna. Thus the deficit of 5-7 billions is obvious”.¹³⁰

¹²⁷ Valeria Lekhan, Volodymyr Rudyi, Ellen Nolte *Health Care Systems in Transition. Ukraine* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004), 25, <http://www.euro.who.int/Document/E84927.pdf> (accessed May 1, 2008)

¹²⁸ *Ibid.*, 33

¹²⁹ *Ibid.*, 33

¹³⁰ Petr Shedriy, “Organizational and economics prerequisites of the development of medical insurance”, *Provisor*, Vol.12, (1998), <http://www.provisor.com.ua/archive/1998/N12/insurance.htm> (accessed May 19, 2008)

In the health expenditure Ukraine remains left behind by Central European countries and some transitional countries of Eastern Europe (Georgia, Belarus). “In absolute terms, Ukraine spends US \$178 PPP per person (2001), which is only 6.6% of the EU average of US \$2226 PPP”.¹³¹

So at that time when nothing changed in legal base there is a huge difference for people, who have to pay out-of-pocket due to the absence of resources in the system of health care. To estimate the share of informal payment is very difficult, however there is a permanent tendency for its increase. “Due to the State Statistics Committee, official payments by the population, excluding voluntary health insurance premiums, amount to 43.2% of the total health budget, and are increasing”.¹³² And unofficial payments are even greater. As it was noted by Lekhan, Rudyi and Nolte, “direct health expenditure by the population is increasing swiftly, with the share rising from 18.3% in 1996 to 30.2% in 2000; including informal payments this proportion is estimated to be even higher, at 51% in 2000”.¹³³ “Recent unofficial assessments have estimated that the total turnover of informal resources in the health sector is now almost 3 billion hryvna (US \$555 million), which is more than half of national consolidated budget envisaged for 2001”.¹³⁴

These trends lead to restricted access to the health care for the majority of population. For example, “a representative survey of 9478 Ukrainian households undertaken by the State Statistics Committee in October 2002 showed that more than a quarter (27.5%) of households were unable to obtain necessary health care for any member of the family). For the majority of respondents (88%–97%) this was mainly because of exceptionally high costs for drugs, devices

¹³¹ Valeria Lekhan, Volodymyr Rudyi, Ellen Nolte., 49

¹³² Ibid., 41

¹³³ Ibid., 40

¹³⁴ Ibid., 41

for homecare and health services. Furthermore, about 9% of households were unable to consult a doctor because of financial difficulties, and another 5% were unable to obtain necessary inpatient treatment for the same reason. The study also demonstrated that a substantial number of hospital patients were charged for drugs (92.9%), food (83.0%) or bed linen (63.9%), the very services that the state health system is by law supposed to provide”.¹³⁵

The reason of inability of budget to provide people with financing for medical treatment is not only the lack of resources but also the structure of spending and inefficient use of resources. For example “in general structure of expenditures on the health care the biggest amount is spent on the wages with charges and is 75% and sometimes more than 80%. Approximately 8% is spent on energy carriers, 8 % - for medical supplies, only 4% is directed on the nutrition of the ill, and the rest are transfers and other spending. As a result the expenses that are not connected directly with the treatment of the patients constitute approximately 90%”.¹³⁶

Decline in health care sphere in Ukraine is also influenced with inflationary processes in general and fast grow of the prices on medicaments and medical equipment. This is weighed down with inefficient usage of financial funds. For example, “there is a problem of dual and triple financing of providing of medical treatment through municipally, departmental and academic medicine that infringe upon the principle of common medical space. That is why it is very difficult to achieve the necessarily results only through simple extension of state financing”.¹³⁷

Another problem is low incentives of the health care institutions which are state funded to improve the services and to compete for the resources. “Now the system of health care financing

¹³⁵ Valeria Lekhan, Volodymyr Rudyi, Ellen Nolte., 37

¹³⁶ Dmitriy Karamishev, et al., “State policy of financing of health care in Ukraine”, *State Building*, Vol. 1, (2006), 4, <http://www.nbu.gov.ua/e-journals/DeBu/e-book/doc/2/02.pdf> (accessed May, 19, 2008)

¹³⁷ The Project of the law «Financing of the health care and medical insurance”, Ministry of Healthcare of Ukraine, http://www.moz.gov.ua/ua/print/?docID=8209&_tpl=prn (accessed May 19, 2007)

is not supposed to purchase medical services from state and municipal institutions of health care with the regard for real cost of these services. These institutions are budgetary institutions and are supported on budget's account. The calculations of funds are realized through calculation of the capacity (the number of beds) and the number of staff of that medical institution. Accordingly to Budget Code these institutions are financed due to the earmarked calculation; that is why they lack the necessarily flexibility and efficiency in planning and usage financial and other resources".¹³⁸

As it was noted before there is no social health insurance in Ukraine at the state level. However some forms of private health insurance are already operating in Ukraine. "But so far they achieved mixed results. The majority of population is not satisfied with the state of social insurance in Ukraine. Only a little percentage of citizens has policy of medical insurance and there is no practice of insuring employees in case of illness that is not connected with production in the enterprises. The factors that affected the low level of medical insurance there are as follows: the absence of the legislative basis, low income of the population, lack of the information on medical insurance, lack of development of insurance market, economic instability in the state".¹³⁹ The experience of countries that provided health insurance proves that that there is a significant improvement of efficiency in hospital functioning when they compete for the resources of patients and particularly for attraction of insurance companies. So the division of financing and providing side seems to be very efficient experience for Ukraine.

There is already some positive experience of operating of private insurance companies in Ukraine. "Voluntary health insurance was legalized in Ukraine by the law "On Insurance" passed

¹³⁸ Volodimir Rudyi, How make "medical" funds to work efficiently?, Financing and management in health care, http://www.healthfin.kiev.ua/pages/leg/arev_u.htm (accessed May 19, 2008)

¹³⁹ Y. Dudenko, N. Bondar, "The peculiarities of medical insurance as a part of social security of the population of Ukraine", *Economica*, (2006), http://www.rusnauka.com/NPM_2006/Economics/3_didenkobondar.doc.htm (accessed May 19, 2008)

in 1996. There are about 100 insurance companies offering coverage of variable degree, however, the VHI sector accounts for less than 1% of total health care spending”¹⁴⁰ and “in 2000, about 800 000 people (about 1.5% of the population) were covered by VHI, with a total of about 36 million hryvna (US \$6.7 million) spent on premiums”.¹⁴¹ However as it is seen on the experience of Central European countries and particularly the case of Czech Republic the usage of private insurance may lead to the escalation of the costs for medical services and this kind of insurance is inappropriate for a country where the majority of population is with low income as large groups of people will be excluded from the system.

“As health insurance companies in Ukraine are generally small, they usually do not run their own health facilities but contract with public facilities. This means that they have only limited influence on the way services are delivered to their customers”.¹⁴² “Corporate (group) insurance purchased by employers is the main form of voluntary health insurance in Ukraine; individual insurance is less common”.¹⁴³ And although the amount of population covered by private insurance is insignificant it has positive impact from the point of view of familiarity of the society with different methods of health care financing and approbation of new schemes of health care financing. But of course it is too early to speak about private insurance as supplementary source of health care financing.

Other sources of health care financing that resemble social health insurance are sickness funds. “The income of sickness funds is derived from a number of sources, most importantly non-earmarked membership fees that are determined as percentage of salary or fixed payment. Other sources include contributions from founders and members, charitable contributions and

¹⁴⁰ Valeria Lekhan, Volodymyr Rudyi, Ellen Nolte., 43

¹⁴¹ Ibid., 43

¹⁴² Ibid., 43

¹⁴³ Ibid., 43

donations and profits from charity transactions”.¹⁴⁴ However they are not widely spread and the funds raised by them are not sufficient to provide their members with all the services.

Thus it might be said that in the absence of modern relations between patients and health care institutions health care system in Ukraine extremely obsolete. The state doesn't meet its commitments as Constitutional guarantee for free health care treatment. There is huge lack is financing of the system which requires additional sources. There is a need to separate the financing and supply sides in order to make system more efficient. Huge financial resources in a form of out-of-pocket payments that pass beyond the system should be controlled and directed to the formation of social health insurance fund in order to preserve the principle of solidarity of the system and enrollment as biggest amount of the people as possible into health care facilities.

3.2 Problem of transformation from the tax-based system to insurance based system in Ukraine

3.2.1 Problems of introduction of social health insurance in a legal sphere

“Now Ukraine is situated at the stage of introduction of state compulsory medical insurance. Respective drafts № 1040 from 27 of November 2007, № 1040-1 and № 1040-2 from 25 of January 2008 are already developed and received inference of profile committee of Supreme Rada of Ukraine. The draft № 1040-2 provides for amendments to Law of Ukraine “About state general mandatory social insurance in connection with temporal loss of capacity for work and losses connected with birth and burial”, Law of Ukraine “About insurance”, the foundations of law about state general mandatory social insurance and the foundations about health care. In particular it is proposed to transform the law of Ukraine “About state general mandatory social insurance in connection with temporal loss of capacity for work and losses

¹⁴⁴ Valeria Lekhan, Volodomyr Rudyi, Ellen Nolte., 44

connected with birth and burial” in a new edition of law of Ukraine “About state general mandatory insurance”.¹⁴⁵

However all these drafts had no practical influence and were rejected by the Parliament. Different legal initiatives concerning introduction of general mandatory health insurance reflect popularity of this topic in society but at the same time they also reflect the struggle of interests among different parliamentary groups and groups of interests in the business and particularly large insurance companies. And again in these documents we can see politicians’ strive for popularity as none of them propose to name medicine a good and to state that people have to pay for it.

The one of the recent drafts that deserves attention in my opinion is Project of the law «Financing of the health care and medical insurance” of T.Bahteva and S.Chervonopilskiy as it has a support from the side of Ministry of Health, which has a decisive voice in the health care sphere. Based on this draft I will try to characterize the vision of social health insurance by leading Ukrainian politicians below.

The main problem for an introduction of social health insurance in Ukraine is a definition of medicine as free of charge by Ukrainian Constitution. “In May 2002 the Constitutional Court revisited the official interpretation of Article 49 in the Constitution dealing with health care to be provided free of charge. In its final ruling it stated that health care offered in state and community facilities should be provided to all citizens “without preliminary, current or subsequent payments”.¹⁴⁶ “It also decided that charging citizens insurance premiums as proposed in the framework of the law on State Social Insurance was in violation of the constitution. At the same time it stipulated, however, that state and community health facilities

¹⁴⁵ Natalia Andrishina, “The prospectives of medical insurance in Ukraine”, *Legal Weekly*, №17-18, 22 April, 4, (2008), <http://www.legalweekly.com.ua/article/?uid=367> (accessed May 20, 2008)

¹⁴⁶ Valeria Lekhan, Volodymyr Rudyi, Ellen Nolte., 37

could charge for services that are considered beyond the limits of health care. In addition, it was deemed possible to mobilize additional resources using voluntary insurance mechanisms and various forms of financial participation of the population (sickness funds, credit unions, etc.)”.¹⁴⁷ However as it is seen from the experience of Central European countries a right to health care and medical treatment guaranteed by Constitution and paying to health insurance fund by patients is compatible. Even with the definition of medicine free of charge with proper formulation and incorporation of social health insurance into the article on Health Care it is possible not to reject people’ right to obtain medicine without payments. So the Ukrainian legislators should consider the reformulation of this statement in the Constitution. For example is it was formulated in Russian Constitution that “Everyone has the right to health care and medical assistance. Medical assistance is made available by state and municipal health care institutions to citizens free of charge, with the money from the relevant budget, insurance payments other revenues”.¹⁴⁸

For example Rudyi propose the following ways out of this legal situation that ensued after passing this decision by Constitutional court: “Either amendments to Article 49 of the Constitution which would allow the usage of regulation of state’s guarantees in the sphere of medical service with a conception of “basic package” recognized in the whole world; or opening new case by the Constitutional Court about the case of medicine free of charge with the regard for new circumstances which were not the subject of its previous consideration and acceptance of new carefully thought out interpretation of Article 49 of the Constitution with the regard of international experience”.¹⁴⁹

¹⁴⁷ Valeria Lekhan, Volodomyr Rudyi, Ellen Nolte., 37

¹⁴⁸ “Constitution of the Russian Federation”, <http://www.servat.unibe.ch/icl/rs00000.html> (accessed May 23, 2008)

¹⁴⁹ Volodimir Rudyi, How make “medical” funds to work efficiently?, Financing and managing in health care, http://www.healthfin.kiev.ua/pages/leg/arev_u.htm (accessed May 19, 2008)

Another way of removing this contradiction is proper interpretation of medical services in a new law of compulsory medical insurance. For example, “in accordance with the Constitution citizens have not to pay for medical services directly in order not to make an obstacle of searching money before people. The very this regulation was inserted by authors into the basis of new draft on compulsory medical insurance: the citizen doesn’t pay for services. Because having bought the medical insurance he invested his money “for the sake of the health of all people of Ukraine” and he is himself insured from this general money”.¹⁵⁰

“Vagueness of legal questions of medical insurance makes this sphere of social relationships very unattractive and unpromising from investing, economic and marketing points of view”.¹⁵¹ That is why in my opinion it is very important first to develop legal basis for the reform and to adopt a law which would suit the wide circles of society thus reducing the incentives for its amendment. The experience of compliance of the Constitution and law on general mandatory health insurance in Central European countries is very good theoretical basis for the development such a law in Ukraine.

3.2.2 Institutional basis for the reform

“The transition to medical insurance causes a wide range of problems; their solving is very actual task. In particular, very important problem is to develop the principles of technical and economical substantiation of according medical services. These principles are necessary on

¹⁵⁰ Oleg Parashak, “Russian and Ukrainian trends of compulsory medical insurance”, *Straxova Sprava*, no. 4, (2005), 3, <http://www.taslife.com.ua/ua/about/publ/06/03/04/157?print> (accessed May 20, 2008)

¹⁵¹A. Nemchenko, et al., “Once more about medical insurance”, *Provisor*, Vol.12, (2001), http://www.provisor.com.ua/archive/2001/N12/art_12.htm (accessed May 20, 2008)

the one hand for insurance companies in order to economically ground the profitability of their activity, on the other hand they are necessary for the agencies of health care management and State financial in order to develop the adequate measures for regulation of health insurance market”.¹⁵²

Without adequate ground it is very unlikely that even well developed plan of reforms works. As it was proposed by deputy of the Minister of Health Care of Ukraine “in the first turn it is necessary to define conceptually, to set the priorities and the stage of implementation of new economic and organizational mechanism of the system of health care. The implementation of new mechanism is proposed to provide in several stages with the development of all main aspects of the reform in them”.¹⁵³ According to him at the first stage it is necessary: “to prepare the proper legal and normative basis”;¹⁵⁴ “to complete the working out and ratification of medical standards; to prepare the necessary economic, in particular price and tariff and other calculation basis, and to define the costs activities of medical services; to complete the organizational and economic transformations in the branch, clearly define the status of subjects and establishments of medical aid; to accept on the state level the necessary decisions concerning the attraction of new sources for the financing of medicine, in particular to define the level of medical insurance payment from single social contribution, directed attraction of funds in the case of increase of excise collections or introduction of the tax on assets”.¹⁵⁵ For these measures approximately one year is needed.

¹⁵² O.Murashko, I. Paznia, “Medical insurance in Ukraine: problems and prospectives”, *Transport Medicine of Ukraine*, Vol.2 (2007), 67

¹⁵³ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

¹⁵⁴ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

¹⁵⁵ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

Further at the first stage for the reforming there should be engaged: “medical institutions of outpatient and stationary aid in rayons, provincial and rayons’ towns; the institutions of oblast character (third level), which are supposed to provide specialized medical aid in the oblast, Kiev and Sevastopol and other big cities; and which have to acquire the status of Universities’ hospitals; the range of specialized establishments (for example dentists’); the private hospitals”.¹⁵⁶

“At the second stage a full range of institutions is supposed to be involved in the reformation of medical sphere, in particular state highly specialized scientific and research centers with hospitals that nowadays are financed from state budget, the stations of ambulance, all the rural medicine and pediatrics. Besides all the population should be involved (with the exclusion of definite categories: those who are placed in prisons, those who has serious illnesses, disabled veterans)”.¹⁵⁷

As we can see the reform is supposed to be provided step by step. And I can agree that with current level of development of medical infrastructure it is impossible to achieve sufficient improvement in the health care system with radical reform. At this point Polish experience of gradual changes and particularly the statement of Berman that “too rapid structural change in eastern European and former Soviet Union states without the preconditions to establish and test these new behaviors has proved to be risky and has led to some significant negative outcomes”¹⁵⁸ is very valuable for Ukraine. Besides the fact

¹⁵⁶ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

¹⁵⁷ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

¹⁵⁸ Peter Berman, 1

Ukrainian medical infrastructure is even more underdeveloped than those of Poland should be taken into the account.

For efficient functioning of social health insurance system it is very important not only to collect funds but also to manage them in a proper way. That is why “one of the supreme problems is the legal definition of the subjects who will take charge of the funds of compulsory medical insurance. The Insurance Bureau within the Ministry of Health Care of Ukraine can not deal with extremely difficult legal, social and economical and medical problems of insurance. The international experience shows that insures and medical establishments have to work with the funds of compulsory medical insurance for a normal development of the market of insurance services”.¹⁵⁹ The answer to this question in the interview conducted by Nemchenko and Panfilova was as follows: 53 of the respondents answered that it should be health care institutions and insurance companies, 41 – that only insurance companies, and 36 – that only the health care institutions.¹⁶⁰ That reflects distrust both for health care institutions as they did not justified confidence of the population in a nowadays system and insurance companies as these are comparable new phenomenon to the people.

So reform in Ukraine can not be conducted with simple introduction of social medical insurance schemes. There is no infrastructure for the social insurance to work in. So in this case I think deeper changes and social health insurance should be introduced only within the reformation of the whole system. The amount and diversity of population in Ukraine argues for gradual reform as firstly the system might be incapable to provide the whole population. For

¹⁵⁹ O.Murashko, I. Paznia, “Medical insurance in Ukraine: problems and prospectives”, *Transport Medicine of Ukraine*, Vol.2 (2007), 67

¹⁶⁰ A. Nemchenko, et al., “Once more about medical insurance”, *Provisor*, Vol.12, (2001), http://www.provisor.com.ua/archive/2001/N12/art_12.htm (accessed May 20, 2008)

example “in 2007 there were registered more than 500 million of requests for outpatient care and more than 10 million cases of hospitalization. It is difficult to imagine which staff is necessary to check the quality of medical aid in every single case. Besides the fund is as a rule has planned budget and thus is interested in the payment to be at the amount of volume and quality of the services granted”.¹⁶¹ Thus the introduction of the social health insurance should be provided in the context of the reformation of the whole health care system and guaranteeing of the preconditions for improvement of the health of the whole population.

In my opinion the business and employers can constitute good source of financing for social health funds. Ukraine will follow the way of developed countries from the point of view of social responsibility of employers. However this change is a subject of long time period. But it can be said that “nowadays in Ukraine modern employer is being formed, which cares not only about profit but also about social needs of his employees. More and more enterprises decide the problems of protection of employees via the system of voluntary health insurance. More and more directors understand that it is more useful to have healthy employee than ill at his manufacture”.¹⁶² This type of new relation can serve as a good basis for the proper functioning of social health insurance in Ukraine that was proved by experience of more developed transitional countries of Central Europe. However as it clearly seen from Russian case a long period of time is needed for adoption of this principle in society.

¹⁶¹ Igor Yakovenko, “Medical insurance: the position of Ministry of Health Care of Ukraine”, *Apteka*, № 17 (638) 28.04 (2008), <http://www.apteka.ua/archives/638/26945.html> (accessed May 19, 2008)

¹⁶² Oleg Parashak, “Russian and Ukrainian trends of compulsory medical insurance”, *Straxova Sprava*, №4, (2005), 3, <http://www.taslife.com.ua/ua/about/publ/06/03/04/157?print> (accessed May 20, 2008)

3.2.3 Problem of financing and the role of the state in medical insurance

As it is proposed by draft on «Financing of the health care and medical insurance» the funds for financing of health care are supposed to come from the following sources: state budget and local budgets, medical compulsory insurance, state general social insurance, voluntary medical insurance and direct payments.¹⁶³ The positive contribution of the draft is seen in the proposition not to include the insurance contributions in a structure of taxes and other compulsory payments that comprise the system of taxation and ascription of social contributions of the employer to the gross expenses of the enterprise. However the establishment of the medical insurance contribution at the level of fixed sum of 6% from living minimum for employees, their dependents and self employed and at the level of 3% for nonworking pensioners, invalids and other persons that receive help at the expense of fund of general mandatory social insurance¹⁶⁴ in my opinion is insufficient and inefficient. I think that more efficient amount would be a percentage from the salary as it established in transitional countries of Central Europe, and which makes system really redistributive and solidary when the rich pay for the poor.

Another aspect is that the system proposed in the draft is overcomplicated and the establishments of many sources for financing of social health insurance fund leave the question about who will be responsible if the system will not be financed on the sufficient level, because if there are many sources responsible for filling the fund it means that no particular body is

¹⁶³ The Project of the law «Financing of the health care and medical insurance», Ministry of Healthcare of Ukraine, Ministry of Health care of Ukraine, http://www.moz.gov.ua/ua/print/?docID=8209&_tpl=prn (accessed May 19, 2007)

¹⁶⁴ The Project of the law «Financing of the health care and medical insurance», Ministry of Healthcare of Ukraine, Ministry of Health care of Ukraine, http://www.moz.gov.ua/ua/print/?docID=8209&_tpl=prn (accessed May 19, 2007)

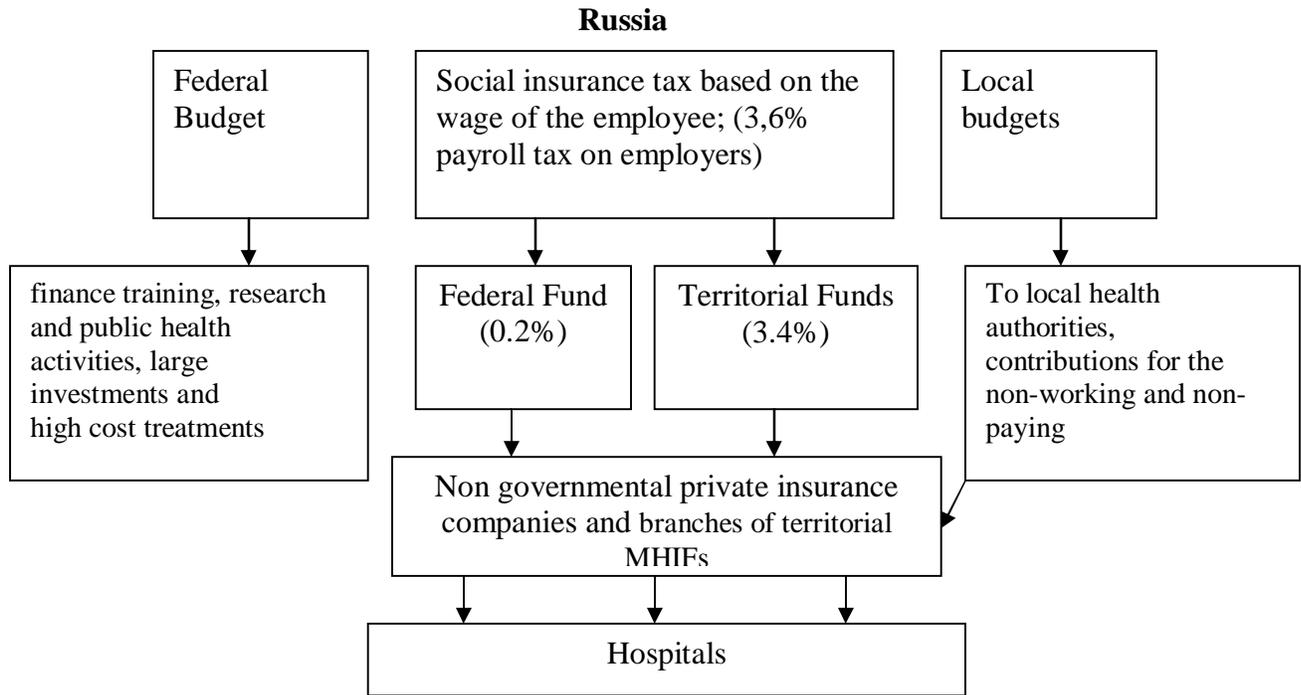
responsible. In comparison with Russian system of financing social health insurance (Figure 3) in Ukrainian system much more sources of financing supposed to be used. Unlike Russia which has payroll tax of 3,6% Ukraine is going to use fixed amount of contribution based on the living minimum. However it must be said that both in Russia and in Ukraine this amount is comparatively low to the amount of Central European countries. This in my opinion might be one of reason of insufficient financing of the system both in Russia and Ukraine.

It was estimated by Mostovich that insurance contribution for one citizen in Ukraine will comprise approximately 30 hrvna (6 dollars) and 15 hryvna for pensioners (3 dollars) in the calculations of 2006-2007, which will be paid by employers and institutions of local governing. This will provide approximately 360 hryvna per year for one person that with the account of uninsured categories will additionally provide 12 billions of hryvna to the budget of health care.¹⁶⁵ However it must be argued that even this amount is not sufficient to cover all the costs in health care. As it was stated by Parashak “in order to make Ukrainian medicine work on the level of 1985 30 billions are needed and even planned revenues from mandatory health care insurance are not able to cover these expenses”.¹⁶⁶

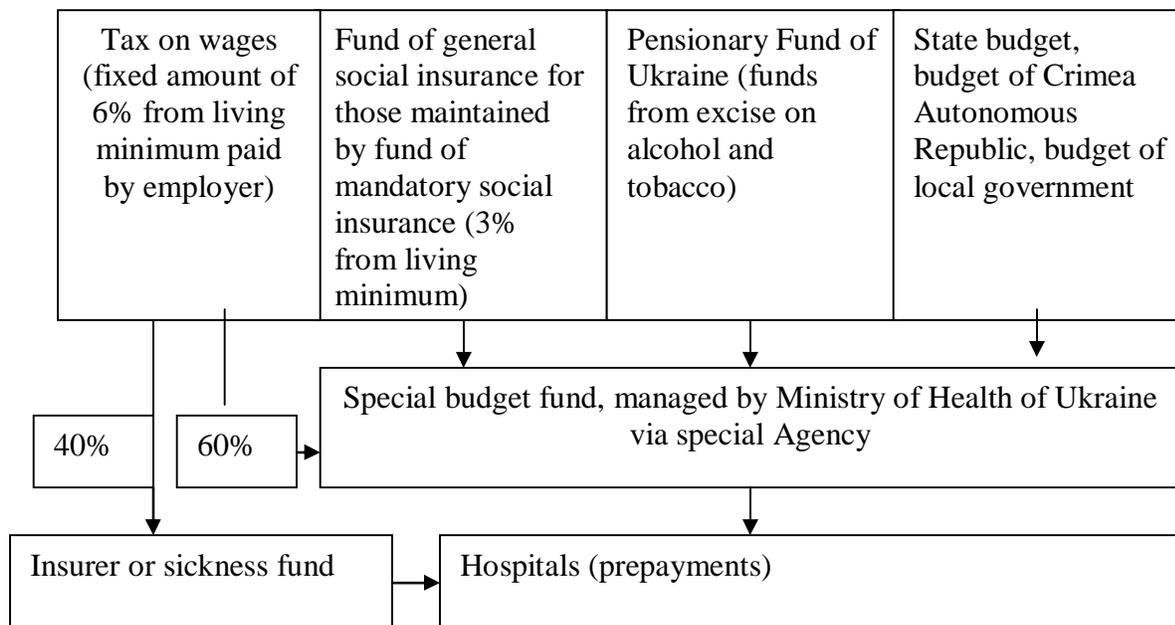
¹⁶⁵ Mikola Mostovich, “The law that suits everybody: both medical workers and their patients”, *Vashe Zdorovie*, Vol.15 (892) (2006), <http://vz.kiev.ua/med/15-07/2.shtml#4> (accessed May 20, 2008)

¹⁶⁶ Oleg Parashak, “Russian and Ukrainian trends of compulsory medical insurance”, *Straxova Sprava*, №4, (2005), <http://www.taslife.com.ua/ua/about/publ/06/03/04/157?print> (accessed May 20, 2008)

Figure 3. The system of contribution to social health insurance funds in Russia (operating system) and Ukraine (based on the draft «Financing of the health care and medical insurance»)



Ukraine



“The structure of medicine financing (in calculations of 2006-2007) will comprise from the funds of state and local budget (21 billions hryvna – 55%) at the expense of which the state programs in health care will be financed and uninsured population will be covered; from the funds of compulsory medical insurance (12 billions hryvna – 35%) at the expense of which the aid for insured population will be provided; from the funds of voluntary insurance and other sources (3,5 billions of hryvna) at the expense of which the aid of better service will be provided. The general budget of health care will compose 36 billions of hryvna or 6% of GDP”.¹⁶⁷ In my opinion these estimated figures are set too high. And the issue that requires consideration is the ratio of pay roll tax on mandatory health insurance and the funds of the budget. As it was proven on the experience of Central European countries earmarked health care contributions are prevalent over state budget and are more efficient sources for health care financing. But Ukrainian project provides that health care insurance contributions will be only supplementary source for health care financing and not going to finance the even the half of health care expenditures. That again raises a question of the efficiency of such a system.

In my opinion introduction of additional taxes that are not connected with pay roll tax on medical insurance are highly inefficient measures and will not contribute to the system of health care. “At present, the level of contributions to social insurance other than health insurance borne by the employers already exceeds 39%. Income tax is also rather high, ranging between 20% and 40%. Therefore, the introduction of social health insurance would require an accompanying tax reform not only to prevent overburdening the system and to address related social problems but

¹⁶⁷ Mikola Mostovich, “The law that suits everybody: both medical workers and their patients”, *Vashe Zdorovie*, Vol.15 (892) (2006), 1, <http://vz.kiev.ua/med/15-07/2.shtml#4> (accessed May 20, 2008)

also to revitalize the domestic economy”.¹⁶⁸ But rather I would propose to increase health insurance contribution of the employer and make it proportionally to the salary.

Also the system that is proposed will cover the expenditures on the same budget basis meaning that state will provide the hospitals with funds accordingly to their estimated needs. But the experience of Central European countries shows that introduction of social health insurance also gives a chance to control spending and to cover costs ex-post. This system seems to be much more efficient and allow reducing corruption and unnecessary spending.

Thus the vision of social health insurance by Ukrainian legislators and politicians in financing sphere differs from the generally admitted vision of social health insurance in the world. Social health insurance is seen more as supplementary source of health care financing and its introduction is aimed to the pursuit of short term goals of covering of budget deficit rather than long term goal of introduction of completely new efficient system.

3.3 The obstacles for the reform problem of adaptability.

However in spite of the legislative initiative activity no law on social medical insurance was adopted in Ukraine. There are several reasons for it. First reason is the contradictions of interests in Parliament. “That part of the deputies that represents the interests of the employers do not admit the part of the draft which propose introduction of new social contribution new charge for the wage. The left spectrum of political forces does not admit the idea of introduction of social health insurance because it considers it as violation of the constitutional rights of the citizens for the medicine free of charge”.¹⁶⁹ Second reason is “negative lobbying from the side of private insurance companies (negative profit, the search for additional sources of financing; the

¹⁶⁸ Valeria Lekhan, Volodymyr Rudy, Ellen Nolte., 36

¹⁶⁹ Volodymyr Rudy, How make “medical” funds to work efficiently?, Financing and management in health care, http://www.healthfin.kiev.ua/pages/leg/arev_u.htm (accessed May 19, 2008)

strive to provide a system of compulsory medical insurance which is directed to many competitive insurers)".¹⁷⁰ Third reason is weaknesses of the drafts themselves, "which are connected with unclear definition of the status of the future Fund of medical insurance and the mechanisms of its functioning".¹⁷¹

Not less important reason is that the situation in the health care is favorable for some providers operating in the system. "It is not a secret that for some part of the health care workers the existing situation in the branch is very acceptable because in conditions of extreme budget deficit many institutions are functioning at the expense of additional resources mainly the private savings of the citizens".¹⁷²

Other reasons for the difficulties with the adoption of social health care insurance are connected with Ukrainian society itself. "Within the period of the monopoly of State Insurance Company and the period of formation of the market of insurance services average Ukrainian has a negative impression about the insurance. In this character he is different from economically developed countries where the health insurance is the integral part of the status in society".¹⁷³ "The population doesn't have a positive experience of the interaction with insurance companies. And consider insurance as nontransparent and unreliable mechanism".¹⁷⁴ To improve the positive image of insurance companies a wide range of measures and time are needed.

¹⁷⁰ Volodimir Rudyi, How make "medical" funds to work efficiently?, Financing and management in health care, 3 http://www.healthfin.kiev.ua/pages/leg/arev_u.htm (accessed May 19, 2008)

¹⁷¹ Volodimir Rudyi, 3

¹⁷² A. Nemchenko, et al., "Once more about medical insurance", *Provisor*, Vol.12, (2001), 2, http://www.provisor.com.ua/archive/2001/N12/art_12.htm (accessed May 20, 2008)

¹⁷³ A. Nemchenko, et al., 2

¹⁷⁴ Petr Shedriy, "Organizational and economics prerequisites of the development of medical insurance", *Provisor*, Vol.12, (1998), <http://www.provisor.com.ua/archive/1998/N12/insurance.htm> (accessed May 19, 2008)

Among other social and economical factors that restrain the development of social health insurance in Ukraine comparably to countries of Central Europe with established social health insurance system are:

- Uncertainty of the social status and prospective of medical insurance. “The phenomenal clash of the medicine free of charge and the realities of the market of chargeable medical services creates impression of no urgency for medical insurance among the majority of population expressed in the statement “I am healthy I don’t need it if I am ill I will find a solution without medical insurance”.¹⁷⁵ That deteriorates the principles of solidarity in society on the basis of which social health insurance is functioning in the Central European countries.
- The problems in tax legislation which puts additional burden on the employers. The contributions into the social insurance are set too high even without introduction of the contribution to health insurance fund. “And revenues raised from this tax are not earmarked meaning that state can dispose of it in any direction. There are no incentives for the employers to pay social insurance contributions as they are to be paid from profit”.¹⁷⁶ However the new draft suggests relating medical insurance contribution with gross expenses of the enterprises. That is considered as a positive achievement. “It is in the interests of the state to create the conditions for the development of medical health insurance with the purpose of maintaining of high level of the professional work force, which is the active element in the processes of social reproduction.”¹⁷⁷

¹⁷⁵ Petr Shedriy, “Organizational and economics prerequisites of the development of medical insurance”, *Provisor*, Vol.12 (1998), 1, <http://www.provisor.com.ua/archive/1998/N12/insurance.htm> (accessed May 19, 2008)

¹⁷⁶ *Ibid.*, 1

¹⁷⁷ *Ibid.*, 1

- Low incomes of the majority of the population. “The possibility to provide medical insurance at the expense of the citizens’ funds is very restricted with the low level of real incomes of the population, delays in wages and increasing of the amount of non-working population”.¹⁷⁸ “Household surveys conducted in Ukraine over 12 years, from 1988 to 1999, found that since 1988, when the absolute poverty rate was 1.6% (using the US\$ 4.30 per person per day benchmark), the rates have been increasing. In 1999, the latest year for which data are available, 81.7% of the population lived on US\$ 4.30 or less per day. That same year, 31.3% of the population lived on US\$ 2.15 or less per day (World Bank, 2005)”.¹⁷⁹
- Really huge budget deficit in medicine sphere which is very difficult to cover with the medical health insurance. “The limited level of earmarked budget financing cause the decrease of the level of medical aid and worsening of the patients’ staying in the hospitals. Even with insignificant decrease in the amount of medical aid and the number of medical workers there is huge lack of financing of the costs of hospitals for medicaments, food, maintenance of buildings and medical equipment. In these conditions it is very difficult to compensate the lack of resources at the expense of medical insurance and to guarantee the high level of medical aid to the insured”.¹⁸⁰
- Undeveloped market and infrastructure for health insurance and generally unreformed medical branch. “The number of companies that have the experience of the providing of medical insurance is very limited. Consequently the general introduction of medical insurance with the participation of insurance companies will require a long period of

¹⁷⁸ Petr Shedriy, 1

¹⁷⁹ “Highlights on health in Ukraine 2005”, World Health Organization, <http://www.euro.who.int/document/e88285.pdf> (accessed May 20, 2008)

¹⁸⁰ Petr Shedriy, 1

time. It is in the interests of the state to grant the support to sectoral and regional initiatives on implementation of different models of medical insurance that will allow working through its mechanisms and accumulating the experience for the development of medical insurance in Ukraine”.¹⁸¹ Form the words of the deputy of the Ministry of Health Care Yakovenko “any experience of other countries can not be copied automatically for Ukraine. First of all because the medical branch in Ukraine is still not reformed. There is no institute of “family doctor” which is the basis for rendering of medical aid in the whole world”.¹⁸²

The implementation of medical insurance without proper reformation of the whole system and without the creating the necessarily conditions for operating of the insurance companies can result even in the worsening of the system functioning instead of its improvement. “If there is no conversion of the system of medical aid and no realization of the proper strategy of increasing of the efficiency of spending and rationalization of the human resources the introduction of compulsory medical insurance instead of positive effect can cause undesirable consequences. They are, for instance, the increase in costs for medical services, additional tax burden on the employees and employers, tax evasion, high costs on the maintenance of the staff of one more fund of social insurance”.¹⁸³

The condition of the health of Ukrainian population and its structure also influence the possibility to introduce the system of general mandatory medical insurance. The condition of the

¹⁸¹ Petr Shedriy, 1

¹⁸² Igor Yakovenko, “The implementation of compulsory medical insurance is possible only in the context of reforming of the whole branch”, (press conference of the Deputy of the Minister of Healthcare of Ukraine, April 09, 2008), <http://moz.gov.ua/ua/main/press/?docID=9797> (accessed May 22, 2008)

¹⁸³ Volodimir Rudiy, Mikola Polischuk, Medical insurance is not a panacea, Zerkalo Nedeli, № 48 (423) 14 — 20 December 2002, <http://www.dt.ua/3000/3450/37040/> (accessed May 22, 2008)

health of the population, working conditions and environment situation in Ukraine is very bad comparably with the countries of Central Europe. And there is a threat that the amount of money raised by insurance fund will not be sufficient even to cover the needs of insured population. This tendency is supported by the experience of private insurance companies operating in Ukraine. “Today medical insurance does not bring noticeable profit for the majority of insurance companies. They work mainly in order to acquire confidence of the clients. A lot of companies spend 80-95% of insurance contributions received; not only on insurance payment but also on the maintaining of the dispatcher's services”.¹⁸⁴

WHO survey shows large percentage of fasting ageing of the Ukrainian population. “The percentage of the population 0–14 years old was relatively steady during the 1980s, but fell from about 21% in 1990 to 16% by 2003. At the other end of the age spectrum, the percentage of Ukraine's population more than 65 years old is above the average of 25 countries of Central Europe and FSU. By 2030, an estimated 22% of Ukraine's population will be 65 years old and older”.¹⁸⁵

There is also high level of unemployed population comparably to the Central European countries. “The total unemployment rate in Ukraine in 2001 was 11.1%, close to the average of 25 countries of Central Europe and FSU of 12.9% for that year, keeping in mind that national rates are based on estimates of people available and seeking employment and that countries have different definitions of labour force and unemployment. The percentage of young Ukrainians, 15–24 years of age, without work but available for (and seeking) employment was 24% in 2000

¹⁸⁴ O.Murashko, I. Paznia, “Medical insurance in Ukraine: problems and prospectives”, *Transport Medicine of Ukraine*, Vol.2 (2007), 67

¹⁸⁵ “Highlights on health in Ukraine 2005”, World Health Organization, <http://www.euro.who.int/document/e88285.pdf> (accessed May 20, 2008)

– the latest year for which data were available. In 2001, the average of 25 countries of Central Europe and FSU youth unemployment rate was 25.2% (ILO, 2005)”.¹⁸⁶

“Nonworking population and population working in budget establishments nowadays in Ukraine comprise approximately 70% of the whole population”.¹⁸⁷ With this tendency it is necessary to define the sources other than employers’ contribution to medical insurance fund or reduce the informal sector of employment.

With the introduction of social health insurance there are also great incentives for free-riding and opportunistic behavior of the insured. For example “according to the DALYs, tobacco and alcohol use place the greatest burden of disease on the Ukrainian male population, and high blood pressure and high cholesterol level place the greatest burden of disease on the female population”.¹⁸⁸ With the introduction of general medical coverage scheme the incentives of people to lead unhealthy style also will increase. That why the reform should be designed very carefully with the encouraging schemes, which were applied for example in several Central European countries.

In spite of the all obstacles I consider the introduction of the social health insurance in Ukraine possible and necessary step. Russian experience of country with a lot of contradictions in medical sphere is the evidence for it. “However it took Russia 10 years before the law of 1991 started to work and now 90% of Russian population is involved in the system of general mandatory health insurance”.¹⁸⁹ So in my opinion the introduction of the social insurance in

¹⁸⁶ “Highlights on health in Ukraine 2005”, World Health Organization, <http://www.euro.who.int/document/e88285.pdf> (accessed May 20, 2008)

¹⁸⁷ “The main basics of Conception of compulsory medical insurance”, Ministry of the Health care of Ukraine, <http://moz.gov.ua/ua/main/?docID=9830> (accessed May 22, 2008)

¹⁸⁸ “Highlights on health in Ukraine 2005”, World Health Organization, <http://www.euro.who.int/document/e88285.pdf> (accessed May 20, 2008)

¹⁸⁹ Oleg Parashak, 3

Ukraine must be well-thought and gradual step with the removing of all those obstacles mentioned above.

Conclusion

I consider the model of social health insurance as the most appropriate for Ukraine. This model of private insurance health care in my opinion is inappropriate for Ukraine with a majority poor population because usually only the rich or people with stable income can afford to buy private health insurance. Therefore this model could exclude a vast number of the population from health care services. The Beveridge budget model of health care financing is close to that of the former Soviet Union and that is why it was unconditionally rejected by transitional countries for example Russia. I consider this model also to be inappropriate for Ukraine, the budget of which is usually unstable and is not sufficient to cover the health care costs. Besides, Ukraine does not have a settled culture of tax revenue and has a high level of corruption. In my opinion the Bismarck model of health care with the mixed sources of financing is the most appropriate for Ukraine. It will allow supplementing of lacking financial sources in the system; will make system more controllable and accountable as there will be no longer general budget coverage but earmarked contribution which will be aimed directly on the needs of health care system.

After the evaluation of Russian experience and based on the peculiarities of undeveloped medical infrastructure and low level of official employment in Ukraine in comparison with Central European countries I would suggest that gradual reform with step-by-step inclusion of the population and possible testing on some regions is better in Ukrainian case. That is why the hypothesis that Ukraine can achieve a level of Central European countries in a shortest period of time is rejected. But in Ukraine even more fundamental changes in the reform of medical infrastructure are needed than in Central European countries.

The success or failure of the reforms depends on the general development of state and economic growth. In those countries with higher level of development reforms proved to be

more successful while in unstable transitional countries such as Russia reforms had inconstant and inconsistent character. That is why the first prerequisite for successful reform in health care in Ukraine is stable development and economic growth in order not to introduce a system which is good in theory but will not work because it will be incapable to raise the sufficient funds.

Based on the experience of other transitional countries it can be stated that for Ukraine it is very important not to let the system to operate on a completely market basis and not to disregard state control for the insurance companies. This is because this will lead to a segregation of the majority of population and costs escalation. The principle of no opting out in social insurance of the studied countries should also be applied in Ukraine in order to preserve the principles of solidarity in the health care and raise sufficient financial sources.

The vision of the social health insurance of Ukrainian politicians and legislators differs from the model introduced in other countries. It is connected with the fact that they consider social insurance as a supplementary source for budget financing at not as a separate all-sufficient system. The contributions to social health fund are incommensurably small in comparison with the Central European countries and even Russia they are also not progressive and set at the fixed amount from living minimum. Instead additional taxes and contribution to Pension and Social insurance fund are proposed that will put an additional burden on the business. The experience of the transitional countries proves that earmarked contributions going directly to social health care fund are more efficient than government and budget financing and they are set the as a main source of financing of the health care. That is why I would propose for Ukraine to establish the share of the contribution to the medical insurance fund at least no less than budget financing with the prospective of its constant increasing.

There are several obstacles for the social health insurance to work in Ukraine on a basis on which it works in other transitional countries. First of all it is obstacles in the legal sphere in particular the absence of the proper legislation on the social health insurance and contradiction of it with the constitution. I do not consider the later as a real obstacle because as it is seen on the example of other transitional countries the principle of the medicine free of charge and the contributions to the health care insurance can coexist. However, to make new system unquestionable the amendments to the Constitution are needed. Second it is undeveloped medical infrastructure. That is why I propose to consider the introduction of the social health insurance in the context of the reform of the whole branch. Third this is the attitude of people towards insurance which lost its credibility during the Soviet times and the days immediately after independence. So the wide range of state measures should be introduced in order to clarify the meaning of social health insurance. And of course the poor state of the health of Ukrainian population, low incomes of the majority of people high level of unemployment and tax evasion also influence the possibility and effectiveness of the introduction of the social health insurance in Ukraine. So a wide range of state measures should be introduced in order to clarify the meaning of social health insurance.

However I consider that transformation from a tax-based system into the social health insurance schemes is needed and is possible to implement. As it can be seen from the Russian example the introduction of this system even in the country with the high level of shadow economy and regional and social diversity is possible. However as it also seen from the Russian example a period of time is needed in order for this system to be implemented not only on paper but also in economic reality. Further analysis is needed to define the ways of introduction the

social health insurance in Ukraine because it can only be considered within the context of the reforms of the whole medical branch.

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