European Union and its Neighbours in a Globalized World 7

Roman Maydanyk
André den Exter
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Ukrainian Healthcare Law in the Context of European and International Law

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Volume 7

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Preface

This book is the product of a project initiated by Ukrainian legal scholars interested in health issues. Ukraine, as other Eastern and Central Europe have been confronted with various challenges in their health care systems. For instance, the introduction of 'market-oriented' elements in the health care systems of the European countries in transition reflects some of the characteristics towards a more Bismarckian health care model upgraded with managed competition tools.

In line with the health system reforms, subsequent governments have revised the health sector's legal framework frequently and it is expected to continue in the coming years. For instance, medical (reproductive) technologies raise various ethical and legal concerns on the legal status of the human embryo, regulating the freezing and storage of human gametes and embryos, and most recently CRISPR-Cas gene-editing technologies in health care. Since these medical-ethical issues raise human rights concerns, legislative intervention is required.

But apart from regulating health care technologies, health system reforms address the organization, planning, and financing of health care services, as well as the need for revising quality of care issues (qualification of health professionals, monitoring complaint and professional review mechanisms, patients' rights, etc.).

Simultaneously, the ratification of international and European treaties by Ukraine also affects its national health system, and thus its regulatory framework. For instance, the Oviedo Convention (1997) including Additional Protocols imposes member states to harmonize their national patients' rights legislation with the Council of Europe's minimum standards. In addition, the so-called Europe Agreement[1] concluded with the European Union will also require the implementation of the health EU acquis (public health, health data protection, market access rules, and health products and services, pharmaceuticals, etc.).

The urgency of revising and alignment of the national legal framework in health care is not unique to Ukraine, as other Central and Eastern countries have been

[1] Ukraine-European Union Association Agreement, OJ EU L161/3, 29 April 2014.

confronted with similar developments, particularly those entering the European Union since the 1990s. What we know from previous system reforms is that there is no universal 'blue print' that should be followed when revising the health care system. But the complexity of the reform process requires an overall and coherent strategy, introducing a step-by-step revision of the legislative framework. Such an incremental approach is based on underlying principles and concept of health law, national priorities of law-making, and legal instruments steering and monitoring the reform process.

Being confronted with the Covid-19 pandemic, a new dimension was added to this research project. The global pandemic has confronted national governments with introducing restrictive measures on human rights that were unthinkable before. Public health protection and prevention justifies restrictive measures such as Covid-track and tracing measures, seizure of nursery homes, postponing non-emergency medical interventions, as well as the debate on voluntary or mandatory vaccination, and emergency scenarios for critical care admissions in hospitals. As the health crisis increases, it becomes painfully clear that national measures are not sufficient and the call for regional and global collaboration becomes more eminent. The exchange of health data, the need for joint procurement of both preventive and curative health equipment, vaccines and pharmaceuticals create unprecedented legal challenges in terms of health data security, the mutual recognition of national standards, as well as potential constitutional challenges derived from newly developed joint actions.

The key objective of 'Europe towards a Globalization of Healthcare Law' is to provide an overview of current developments in Ukrainian health law and health legislation, with an emphasis on the Eastern and Central Europe in terms of Globalization, ranging from the unified model of healthcare, patient's rights, concept of patient autonomy to post-mortem organ and cell donation, biobanks, medical liability and alternative disputes resolution in health care, vulnerable groups (children), new (reproductive) technologies, intellectual property in medicine and pharmacy, intellectual property protection of the DNA sequence, pan-European treatment contract, managed entry agreements, and prevention of occupational morbidity as a component of public health.

Each contribution examines the applicable norms, identifies legal obstacles and (future) challenges, and suggests recommendations for improvement. Occasionally, it includes valuable lessons learned from other legal systems, adopting international and European values in health care. Although far from complete, the editors hope this book will contribute to increase the understanding of health law in Ukraine, both at national and international level.

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We are indebted to Iryna Izarova for her help with this work preparing and finalizing, to Julia Baklagenko and David Phelan for their comments which enabled us to correct language errors and clarify the presentation.

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Abbreviations

ADR	Alternative Dispute Resolution
AHR	Assisted human reproduction methods
ART	Assisted reproductive technologies
BGB	German Civil Code (*Bürgerliches Gesetzbuch*)
CC of Ukraine	Civil Code of Ukraine
Community acquis, EU acquis	Acquis communautaire
Convention on Human Rights and Biomedicine, Oviedo Convention	Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine
COVID-19	Coronavirus infection SARS-CoV-2
CRC	Convention on the Rights of the Child
CTR	EU clinical trial rules
DCFR	Principles, Definitions and Model Rules of European Private Law: Draft Common Frame of Reference
DRC	Declaration of the Rights of the Child
ECHR	Convention on Human Rights and Fundamental Freedoms
ECOSOC	United Nations Economic and Social Council
ECtHR	European Court of Human Rights
EMA	European Medicines Agency
EPO	European Patent Office
EWCA Crim	England and Wales Court of Appeal (Criminal Division)
FC of Ukraine	Family Code of Ukraine
FDA	U.S. Food and Drug Administration
Fundamentals	Fundamentals of the legislation of Ukraine on health care

GAVI	Global Alliance for Vaccines and Immunization
ICESCR	International Covenant on Economic, Social and Economic Rights and Cultural Rights
ILO	International Labour Organization
MEAs	Managed Entry Agreements
MHRA	Healthcare products Regulatory Agency
The EU-Ukraine Association Agreement	Association Agreement between the European Union and the Ukraine
TRIPS, Agreement TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization
WIPO	World Intellectual Property Organization

Part I
General Provisions of a Healthcare

Europe Towards a Unified Model of Healthcare

Roman Maydanyk and Nataliia Maydanyk

Contents

Abstract The pan-European unified legal model of the healthcare is a system of legal norms, which are provided by the legal instruments of European unification and contain principles and decisive characteristics (determinants) of healthcare in European countries at national and international levels. These determinants combine recognized values and operative principles in the EU with principles of acceptable economic efficiency and growth of healthcare of any European country, taking into account common and distinctive features of the European countries, developed economies and countries in transition. This healthcare model should be the basic

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healthcare standard, setting a minimum level of healthcare for European counties, combining universal health coverage with public and private hospital and ambulatory care to secure a high level of healthcare provision. This model provides for equal participation of consumers in the payment for medical services, necessary to avoid excessive use of medical services as well as other tools of managed competition under tight control and regulation of the state, taking into account European values and principles, financial and institutional ability, mentality and other national traditions of European healthcare systems. The instruments of unification of European law should provide a common frame of reference for the pan-European unified healthcare model, which will define the basic principles, characteristics (determinants) of said unified model, principles of international policy. It should also secure the exclusive competence of national law, the interrelation of international and national healthcare policies based on the exclusivity of the competence of national law and the subsidiarity of the norms of the international healthcare law.

1 Introduction: Background and Objectives of the Study

The need for sustainable development of European health care in terms of globalization necessitates the approximation of national law through the use of legal instruments of harmonization and unification at different levels to better succeed in combining European values and principles with economic efficiency and growth. EU Member State and countries within the Association Agreements and European Neighborhood should have effective and predictable systems (models) of healthcare.

Despite the diversity of healthcare models, the system of legal characteristics (determinants) of the European unified model determines the primary and derivative characteristics, which are inherent to different European countries and reflect the common development of health care systems.

The ideological basis of any health care model is a system of basic characteristics (determinants) of the model comprising a general understanding of medical services as a social good. The legal uncertainty of such a system hinders the efficiency and predictability of the health care model.

At present, EU acquis and national law of the European countries on the model of healthcare law and their decisive components are not unified.

The acute relevance of these issues is due to the differences between the national Law of EU-member states and other European countries in terms of variety of healthcare systems and set of their decisive characteristics. This makes it difficult to define unified approach to achieve acceptable efficiency and growth of all European healthcare systems.

To approximate and harmonize the national law of European countries and EU-healthcare law, it is essential to form a common frame of reference of the pan-European model of healthcare, in particular, principles, decisive determinants (characteristics) of this model, which combine European values and principles with

acceptable economic efficiency and growth of the healthcare of any European country.

Thus, in this chapter, we will try to outline the concept and basic provision of the European unified model of healthcare law in terms of globalization to better succeed in combining European values and principles with economic efficiency and growth. The comparative component of this study should help identify the peculiarities of healthcare models in European countries, developed economies and countries in transition to formulate the relevant balanced characteristics (determinants) to be taken into account in the unified model of healthcare.

2 Legal Analysis of the Pan-European Model of Healthcare

2.1 Concept, Principles, and Levels of Healthcare Models

The healthcare model should be considered as a system of legal norms that determine the main characteristics (determinants) of healthcare based on the principles of affordability of price, affordability of providing, and reliability of healthcare services.

The mentioned three principles are the key principles of health care, which correspond (correlate) with the values and principles of healthcare recognized in the EU.

The healthcare systems in the European Union contribute to social cohesion and social justice and are treated as an important element of 'a social state' and the key part of Europe's high level of social protection and.

Council Conclusions on Common values and principles in European Union Health Systems (2006/C 146/01)[1] recognize the overarching values of universality, access to good quality care, equity, and solidarity as values of healthcare which have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe.

Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of national health systems and the need to ensure accessibility to all of them; equity relates to equal access correspondent to the needs and regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles. All health systems in the EU aim to make the provision which is patient-centered and responsive to individual needs.

[1] Council Conclusions on Common values and principles in European Union Health Systems (2006) C 146/01. https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF.

The operating principles of health care consist of principles of (a) Quality: All EU health systems strive to provide good quality care, (b) Safety: Patients can expect each EU health system to secure a systematic approach to ensuring patient safety; (c) Care that is based on evidence and ethics; (d) Patient Involvement: All EU health systems aim to be patient-centered; (e) Redress: Patients should have a right to redress if things go wrong; (f) Privacy and confidentiality: The right of all EU citizens to the confidentiality of personal information is recognized in EU and national legislation.

It is important to understand that the healthcare model is dynamic by nature and should take into account important social changes in the healthcare sector, including the impact of global challenges. One of the manifestations of globalization is the pandemic coronavirus COVID-19 which at present is not a fully controlled global challenge. This global challenge significantly affects the general understanding and unification of the model of healthcare law, necessitates a reconsidering of the concept, characteristics (determinants), and legal instruments of approximation and unification.

Reconsidering the concept, approximation and unification of the healthcare law model implies the need to understand them at different levels: national and international (regional and global), public and private. At the national level, the model of healthcare law shall be a system of basic and derivative characteristics (determinants) provided by national law, which are decisive for the formation of the national healthcare system.

At the international level (regional and global), the healthcare model of law shall be defined by international legal acts, other sources of international law, and legal provisions that define international healthcare policy and the principles of interaction with national healthcare systems. The model of healthcare law should be considered at the public and private levels, which provides for the existence and consideration of public and non-state (private) healthcare. As a result, the healthcare system aquires a two-level character.

At the level of public law, healthcare shall be understood as a healthcare system provided by public (state and municipal) healthcare facilities and physicians who are government employees providing state-funded healthcare services.

At the level of private law, healthcare shall be a system of private healthcare provided by private healthcare individuals and entities and private healthcare insurance. Medical and other healthcare in private healthcare are paid at the expense of consumers, first of all, for better and additional services. Private healthcare fills the gap in the supply of healthcare insurance and in healthcare in general.

Thus, the pan-European unified model of the healthcare law is a system of legal norms of ‘strict’ and ‘soft’ law, which are provided by the instruments of unification of European law and contain decisive characteristics (determinants) of public and private health care in European countries at national and international levels. These norms correspond to the recognized EU values (universality, access to good quality care and solidarity) and the operative principles of health care (quality, safety, evidence and ethics, redress, privacy, and confidentiality), take into account

common and distinctive features of European countries, developed economies and countries in transition.

2.2 Types of Healthcare Models

Generally, the typology of healthcare (i.e., the division of healthcare into types, or models) determines the main characteristics (determinants) of the health care that ensure affordability of price, affordability on the provision of medical services, and reliability of health services.

Usually, in legal doctrine, there are four major models for health care: the Beveridge Model, the Bismarck model, the National Health Insurance model, and the out-of-pocket model.[2]

The Beveridge model is known as 'socialized medicine' because all citizens of a country will have healthcare that is financed by their government using tax payments. Since the government owns hospitals and other medical centers, most physicians are considered government employees. Healthcare costs are also low because the government is the sole payer, which eliminates market competition. The idea behind this system is that healthcare is a human right and citizens are guaranteed universal coverage. Because patients contribute through taxes, they do not have to pay anything out of pocket for medical services. Additionally, a disadvantage of a system that provides equal access to everyone is long waiting lists and over-use that can lead to higher costs. In times of a crisis, a decrease in public revenue can lead to a decrease in funding for services while patient numbers increase, causing a burden on the system. This model was developed in the United Kingdom and has spread to Northern Europe and other countries such as Spain, New Zealand, and Cuba.[3]

Bismarck model 'All Payers' uses a workplace insurance system, quite often through semi-private 'health insurance funds'; the insurers are called 'sickness funds,' usually financed jointly by employers and employees through payroll deduction. These insurance funds may operate within one or more sectors of the economy.

At the same time, the number of contributions and payments are set by the state. Quite often such contributions are just a kind of payroll tax and are paid directly to the appropriate fund. Unlike the U.S. insurance industry, Bismarckian health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private. The amount of remuneration they receive for services is set as a result of negotiations with the funds, sometimes on an individual basis and sometimes on a national scale. Beveridge Model envisages tight regulation that provides the government with a significant impact on the cost control. German

[2] Chung (2017).

[3] Shikha (2020).

healthcare had long been regarded as a model of this system. This model usually includes France, Belgium, the Netherlands, Japan, and Switzerland.[4]

The National Health Insurance model 'Single Payer' has elements of both the Beveridge and Bismarck models. It uses private-sector providers, but payment comes from a government-run insurance program that all citizens fund through a premium or tax. These universal insurance programs tend to be less expensive and have lower administrative costs than American-style for-profit insurance plans. The National Health Insurance system also controls costs by limiting the medical services they pay for and/or requiring patients to wait to be treated.

The state tends to develop a total budget for healthcare when deciding how much of the budget should be allocated for this purpose, and sets the price or volume of compensation to those who provide medical services. In some cases, physicians are government employees who receive salaries. In others, they remain independent and receive compensation on the volume of services provided and treatment measures taken. Within the strictest version of the single-payer system, private healthcare insurance and other ways to 'move beyond voluntary' public medicine are prohibited. The classic National Health Insurance system can be found in Canada; such healthcare model has spread also in some other countries (Taiwan, South Korea).[5]

Out-of-pocket model—'Pay-to-Play' is used in rural areas of India, Africa, China, South America). Only the developed, industrialized countries—perhaps 40 of the world's 200 countries—have established health care systems. Globally, most nations are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die.

As a separate healthcare model sometimes the Patchwork model—'A Little of this, a little of that' is considered, such as model, applies in the US. The patchwork model is an informal term because this model has elements of all four previously mentioned systems in this fragmented national health care apparatus. When it comes to treating veterans, this model is British, for Americans over the age of 65 on Medicare it is Canadian model, for working Americans who get insurance on the job it is German. For the uninsured or underinsured, the US model is rural Indian, with access to a doctor available if you can pay the bill out of pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital.[6]

It is worth noting the classification of the model of a single-payer, the model of health insurance at work, and the model of managed competition. The first two models correspond to the Beveridge and Bismarck models. The latter one—the model of managed competition—involves the provision of medical services by

[4] Tanner (2008).

[5] Wallace (2013).

[6] Summary of international health systems (2011). http://caphysiciansalliance.org/wp-content/uploads/2011/11/International-Comparison.pdf.

private providers, but this market is 'artificial' because it is under tight control and regulation by the state.[7]

In most cases, the state requires citizens to purchase a healthcare insurance policy, which is often combined with the obligation of employers to insure their employees. Patients can choose an insurance company as well as a healthcare provider within a regulated market. Although the standard insurance 'package' is set by the state, insurance companies are allowed to compete with each other on prices, the level of equity participation in the payment of services, and additional coverage. In its purest form, a comprehensive insurance system based on managed competition operates in Switzerland, and recently the healthcare system of the Netherlands has also transferred to a similar basis.[8]

There are some significant differences within these general categories. In some countries, such as France and Japan, the share of consumers in the financing of healthcare is quite significant—so they try to avoid unnecessary requests for medical care and excessive costs for these needs. In other countries, the amount the consumer is obliged to pay out of his/her pocket is limited. Sometimes citizens are allowed to choose medical facilities and the purchase of alternative or additional policies from private insurers is widespread, while in other countries private insurance is prohibited or underdeveloped. Resource allocation and prioritization also vary widely. In Japan, for example, substantial sums are being invested in new technologies, but compensation for surgery is limited, and France has an unusually high level of prescription drugs.[9]

While in theory these categories have distinct policy separations, in reality, most countries have a blend of these approaches, though they generally have a single health care system.[10] The latter may include the following models: 'the southern model',[11] 'the Nordic model',[12] 'budget-insurance model of countries with economies in transition.'[13]

2.3 *Primary and Derivative Characteristics of Healthcare Model*

Despite the diversity of healthcare models, the system of legal characteristics (determinants) of the European unified model is determined by the primary and

[7] Enthoven (1993).

[8] Tanner (2006).

[9] Tanner (2008).

[10] Reid (2009); Summary of international health systems (2011) http://caphysiciansalliance.org/wp-content/uploads/2011/11/International-Comparison.pdf.

[11] Ferrera (1996).

[12] Andersen et al. (2007).

[13] Voronenko and Skorohod (2014).

derivative characteristics, which are inherent in different European countries and reflect the common development of health care.

The principle underlying the model, i.e. the recognition of the nature of medical services as a social good, should be considered as a decisive primary characteristic of the healthcare model.

Derived characteristics (determinants) of the healthcare model are: (1) the scope, quality, availability, and range of available medical services; (2) sources and methods of financing healthcare (according to the rules of social insurance, etc.); (3) unification of general provisions for providing medical services; (4) dualism and/or monism of contracts for providing medical services; (5) control of funds spending efficiency; (6) the legal status of providers of healthcare services as subjects of private or public law; (7) the share of healthcare expenditure in the gross domestic product; (8) use of new technologies; (9) price regulation, other permissible restrictions of the state on medical services.

Each of these healthcare models is based on a different understanding of what healthcare goods are. The principle underlying the model of healthcare concerns both the role of the state and the understanding of the 'goods' in the field of healthcare and the social essence of medical services for society. World practice has formed three main approaches to understanding medical services: as a public, quasi-public, and private goods, which determines the existence and scope of the state's obligation to control the healthcare system.

The state-funded and social insurance models of healthcare recognize a medical service as a public or quasi-public good, which is bought and sold under state control in accordance with restrictions established by law (state-regulated prices, etc.) and taking into account the social purpose of this service. In the market model of healthcare, medical service is considered as private goods that are bought and sold like any other product, regardless of their social purpose and with minimal restrictions by the state.

The attitude to medical services as a private, public or quasi-public good determines the role of the state in the healthcare system, the formation of prices for medical services, and the remuneration of employees in this field.

One of the decisive characteristics of the healthcare model is related to the legal models of medical services applicable in the national healthcare system, which differ in the legal grounds for their providing and the turnover of medical services under the rules of private law or public law.

In European countries two main models for the rendering of medical services can be roughly distinguished: monistic and dualistic. The monistic model for medical services stipulates that the relevant medical services are provided according to the rules of civil (private) law services, and medical services, provided on behalf of a public authority (state or regional community)—according to the rules for providing of public services, to which the provisions of public law apply unless otherwise stipulated by law. The dualistic model for rendering medical services lies in the ability to provide medical services according to the rules on rendering of civil (private) services, or according to the rules on rendering of public (administrative) services.

An example of a monistic model for rendering medical services is the law of Ukraine, where medical services are mainly provided based on contracts (contract for rendering of medical services, contract of medical care under state medical guarantees) under the rules on civil law services. Even if the medical service is provided by the state or municipal healthcare entity based on a public healthcare contract, these medical services are subject to the general provisions of the CC of Ukraine on services and performance of obligations, not the provisions on public (administrative) services and administrative contracts.

The dualistic model for rendering medical services is provided by the law of some European countries (in particular, Germany), which implies dualism and/or monism in models of healthcare delivery. Thus, German law provides rules for classifying the legal relationships for the provision of emergency medical care in the field of public law or private law according to the dualistic system and model of accession. The Accession model ('Eingliederungsmodel') provides for the provision of public emergency medical care on behalf of, at the expense of, and at the disposal of the respective federal state with which private entrepreneurs can cooperate. The Dualistic System (Dualistisches System) provides for the existence, along with the public, emergency medical care with the participation of private entrepreneurs acting on their behalf and at their own expense.[14]

The affiliation of the relevant national model of healthcare to centralized or decentralized healthcare systems, or their combination, in some respects, determines the social demand for the formation of the defining characteristics (determinants) of the European unified model of healthcare, which acknowledges the affiliation of healthcare to private good or quasi-public good.

Medical service is a private good in the case of its provision based on a contract for rendering of paid medical services, the party to which are private persons (for example, a private hospital-provider and a patient or other customer), or on other legal grounds based on legal equality and free will of the parties, if between the participants of the obligation there are no relationships of public power and subordination.

Medical service is a quasi-public good in case it is provided on the ground of an administrative act/order, on behalf of the subject of administrative power (state, municipal community) based on administrative power subordination between the participants of these legal relationships. The provision of medical services on the ground of an administrative act does not turn such services into a public good.

Obligations regarding medical services provided on the ground of an administrative act are of a civil nature, at least in part of the performance of such obligations, as comply to the general rules of performance of obligations under the Civil Code, given the administrative legal grounds for their provision.

[14] Martis and Winkhart-Martis (2014), p. 122.

2.4 *Effectiveness of the Healthcare Model: Towards a Unified Hybrid Healthcare Model in Europe*

The healthcare in each country is a product of its unique characteristics, history, the political process, and the national character of the people; many of these systems are currently undergoing major reforms.

An analysis of the best European healthcare models gives grounds for the general conclusion, that the strength of any national health and welfare system is the domestic people's adherence to the fundamental principle of contribution based on the ability to pay, and the receipt of care on the basis of need. This type of system ensures solidarity and freedom; for patients, freedom in choice of physician and for health care professionals, the freedom to set up practice and prescribe.[15]

At the same time, today, in many European countries, there is a general trend towards the formation of hybrid nature of the healthcare, which makes it possible to avoid some of the most serious problems inherent in other models,[16] including public and market healthcare systems.

The use of state-funded centralized healthcare in all European countries causes the need for mechanisms of managed competition to avoid excessive regulating of medical services and the threat of increased costs.

Managed competition in health care is defined as a purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles, according to which a sponsor (either an employer, a governmental entity, or a purchasing cooperative), acting on behalf of a large group of subscribers, structures and adjusts the market to overcome attempts by insurers to avoid price competition.[17]

Finding a compromise solution to competition in state-guaranteed health care is a complex process involving sometimes the inconsistent, even paradoxical, behavior of their actors.

The irony is that those who most loudly called for competition as the ultimate means of achieving a sustainable, affordable health care system are the very same players who are now opposing any change. Competition is fine as long as it affects everybody except oneself.

Compromise on this issue extends to the limites of achieving certain incentives to improve the quality and efficiency of health care in order to strike a balance in the form of an agreement that meets the needs of all parties—patients, health care facilities and the state, which guarantees the health care.[18]

To avoid the excessive regulating of medical services and the threat of increased costs, the most of the European countries try within of their healthcare reforms to

[15] Cases (2006).

[16] Tanner (2008).

[17] Enthoven (1993).

[18] Lisac and Schlette (2006), Cases (2006).

modernise hospitals, and improve health systems organization and management. They aim to change the behaviour of key actors and place a special emphasis on the monitoring of health care expenditure by health care professionals. The reforms, in particular, focus both on the renewal of the organisation and management of the health system on one hand, and financial measures and incentives on the other.[19] Moreover, the reforms will have strong implications for modernising hospitals and other health facilities. The Modernising hospitals usually has several tiers: firstly, the use of an approach based on a key concept—complementairity; secondly, an important reform of hospital funding with activity based payment; and finally, structural reforms placing more emphasis on clinical services in hospitals.

In this context, the most successful experience of building an effective healthcare model among European countries (in particular, France)[20] shows that the effectiveness of the pan-European unified model should be associated with such a feature as a significant share of patients in the payment for medical services aiming at avoiding excessive use of medical services.

The ability of the state-funded healthcare model to contain rising medical costs is largely due to the possibility of an innovative solution by the national healthcare system of one of the most difficult policy issues in this area: the phenomenon of economic nature called 'moral risk.' Moral risk is the tendency of people to overconsume goods and services if it provides them with higher benefits without a corresponding increase in costs. In other words, it means that people eat more at all inclusive buffet because they can get additional portion for free, likewise, they tend to seek medical services more often because they have paid for them in advance in the form of insurance premiums, rather than upon receipt.

The obvious solution is to transfer a larger share of the cost from premiums in the share participation or insurance deduction, thereby increasing consumer's awareness of the real costs of each 'unit' of healthcare service they receive.[21]

An important role in the formation of an effective healthcare system plays the availability of a largely unregulated market of private healthcare insurance that fills the gaps of supply on medical insurance market. Besides, consumers should be allowed to pay extra for better and additional services, as a result of which the healthcare system aquires a two-level character. These features do not correspond to the most common notions of what public healthcare should be.

The healthcare model should provide mechanisms for resolving the general contradiction related to healthcare services provided by the state: most people do not want to pay more for them (either by raising taxes or directly from their own pockets), and at the same time, citizens are concerned that cost containment measures may lead to a deterioration in the quality of services in the future.

In this regard, the healthcare model should take into account the peculiarities of the national character of the relevant country. Thus, two-thirds of the consumers of

[19] Cases (2006).
[20] Tanner (2008).
[21] Klein (2007).

healthcare services in France expressed the view that the quality of healthcare services is not as important as comprehensive and equal access to these services. This means that the French experience would probably be difficult to implement in another country, whose citizens are characterized by a much less egalitarian ethic.[22]

Thus, the European unified healthcare model should combine universal coverage with a public-private mix of hospital and ambulatory care and a broad service provision taking into account financing and institutional ability of the national healthcare system.

Unlike countries with a liberal healthcare model, all European countries predominantly use a public healthcare system, which determines their differences and main characteristics (determinants).

In contrary to the liberal model and other healthcare systems, the undoubted advantages of state health care models used by European countries (Beveridge, Bismarck, budget and insurance, etc.) are: less expenditure on health care administration in comparison with other systems, better than in other systems healthcare output, the issue of the fundamental moral decision to provide health care coverage to all citizens. European countries that have embraced universal health coverage for their citizens have outperformed the other health care systems on indices of cost, quality, and choice—three key principles of an effective health care model.[23]

However, compared to the US-healthcare system, the disadvantages of European state-funded healthcare models include: insufficient use of advanced medical technology, prescription drugs and research in the field of healthcare; less effective healthcare measures for patients with cancer, pneumonia, heart disease, and AIDS.[24]

The disadvantages of healthcare normativity, provided by state funding, may be eliminated by managed competition rules by combining economic efficiency and growth of healthcare with a peaceful labour market, a fair distribution of income and social cohesion, taking into account present challenges to the healthcare model, including globalization and demographic change. This model will remain viable and successful only if the challenges and the need for reform are understood—and if action is taken. In particular, productivity in healthcare services could be enhanced by having them subjected to competition from other public or private providers. Raising efficiency in the provision of public healthcare services is indeed essential for resolving the fiscal dilemma. Increase in privatization and/or outsourcing of public healthcare services may in some cases help raise efficiency if difficult and important issues of governance can be successfully dealt with. Growth increases the tax base and tax revenues—but also the public sector wage bill and transfers as well as the demand for welfare services.[25]

Any healthcare model that exists in European countries has its advantages and disadvantages, which makes it impossible to determine which of them is the most

[22] Rodwin (2003).

[23] Reid (2009).

[24] Tanner (2008).

[25] Andersen et al. (2007).