EXPERIENCE OF THE USA CONCERNING AN ORGANIZATION OF HEALTHCARE SYSTEM FOR THE PHARMACEUTICAL PROVISION FOR PRIVILEGED CATEGORIES OF CITIZENS

Shapovalov V.V. (Jr.)[1, 2, 3], Gudzenko A.O. [1], Andrieieva V.V. [1, 4], Shapovalova V.O. [1], Shapovalov V.V. [5]

[1] – Kharkiv medical Academy of Postgraduate Education, Kharkiv;
[2] – Advocates company "Apotheosis", Kharkiv;
[3] – Ukrainian national bar association, Kyiv;
[4] – Luhansk State Medical University, ; Rubizhne;
[5] – **Department of Healthcare of Kharkiv Regional State Administration, Kharkiv;**
e-mail: pharm_law@ukr.net

Introduction

Nowadays there is no ideal healthcare system for medical and pharmaceutical provision for privileged categories of citizens in the world. Healthcare systems for medical and pharmaceutical provision for different categories of population of every country, which are the result of historical conditions and economic development, are continuously reformed.

Economic approaches to planning of healthcare and pharmaceutical provision as a commodity system threaten the adverse impact on a health of privileged categories of citizens and the functioning of the healthcare system in general. Thus, the best approach is to learn the experience of other world countries in reforming of the healthcare system for medical and pharmaceutical provision for privileged categories of citizens, with a constant assessment of the changes, that taking place and readiness to adapt the system to changing external conditions, with the obligatory observance of all ethical requirements [1, 2].

Therefore, to create an effective system of pharmaceutical provision with medicines for privileged categories of citizens in Ukraine will consider the same experience of leading world countries with different principles of financing and organization of healthcare system.

Formulating the goals (tasks) of the article

The purpose of the research was to learn the experience of the United States as one of the leading, socially and economically developed countries in the area of organization of healthcare system for the pharmaceutical provision with medicines for privileged categories of citizens.

Presentation of the main research material (methods and objects) with the justification of the results

Conducted a retrospective analysis of healthcare system reform, which applied in the USA during the period from 2000 to 2018. During a research used the following *methods* of analysis: normative and legal, documentary, comparative.

Results and their discussion. The United States of America is practically the only country in the world with a developed economy where there is no publicly available medical care. According to the WHO, the American health system ranked 37th out of 191 countries by the level and effectiveness of overall healthcare, although USA healthcare costs are 15.7% of gross domestic product (GDP) [3].

Need to note, that the United States of America passed ahead of these countries that spend almost two times less on the healthcare system (as a percentage of GDP): Oman – 2.4%, Singapore – 3.1%, Malta – 7.5%, Andorra – 7.6%, Japan – 8%, Great Britain – 8.4%, Spain – 8.5%, Italy – 8.7%, and others. According to the figures of the general level of health of the population (life expectancy, child mortality, etc.), the USA ranked 72th in the world.

The United States, with its global leader, leading economies, annual budget, several times the budget of any other state, cannot provide the appropriate level of provision and availability of medical care and pharmaceutical provision for the population and its privileged contingents [4]. In addition, part of the USA public spending in total healthcare costs is only 45%, much lower than in any other country of the Organization for Economic Cooperation and Development (OECD) [5].

Only the insurance of senior citizens (over 65 years of age), disabled and some other privileged groups can cover by these funds. Although, other OECD countries need less costs for providing a minimum level of publicly available medical service and pharmaceutical provision for all population. The number of practicing doctors in the USA is 2.4 per 1000 population, which is also lower than the average rate of OECD countries – 3,1 [6].

That is why there is a need to analyze of healthcare system of the USA and the realization of the rights of the privileged categories of citizens for getting quality medical care and the provision of medicines. The main sources of financing of the American health system are private and non-commercial insurance, which covers approximately 85% of the population (about 50% are insured by their employers, 10% are self-insured, the rest are insured under the state programs).

Due to current figures, 46 million of Americans do not have insurance coverage at all and costs on medical and pharmaceutical provision held by themselves [7]. This is because of the insurance of half the country's population depends on employers (private insurance), so the availability of medical care and the provision of medicines for most Americans depends on their employment status. In the context of the economic crisis, which began in 2008, the negative situation in the area of availability of medical care and the provision of medicines has intensified.

Nowadays, the number of Americans who do not have health insurance is much higher, as many workers have lost their jobs, and as a result, they lost employers' health insurance. According to the Center for Economic Progress of the United States, for the period end of 2008 and beginning of 2009, employers reduced on 5.1 million jobs. Thus, at the beginning of 2009, 2.4 million workers lost their health insurance [8]. Non-commercial insurance plays a significant role in the USA healthcare system, which is a state program of support for the privileged categories of citizens.

First, it is the federal Medicare program, which covers almost 45 million senior citizens and people with

DOI: 10.5281/zenodo.2639521

disabilities. Secondly, it is a federal-regional program Medicaid, which extends to the poorer sections of the population. The introduction of these programs implemented by the Social Security Act of July 30, 1965, initiated by President Johnson L. to finance the costs of medical care and pharmaceutical provision for the senior citizens and other socially vulnerable groups of the population (Table 1).

Table 1. Directions of medical insurance under the federal program Social Security Medicare

Category of the population	Conditions or characteristics
Persons under the age of 65	Legitimate presence in the USA is at least 5 years old; paying taxes and insurance for 10 years or more
Disabled older age group	Getting disability benefits for at least 24 months
Patients with chronic renal insufficiency	Need for hemodialysis or kidney transplantation
Persons suffering from amyotrophic lateral sclerosis and those entitled to social insurance in case of disability.	Providing free in-patient treatment and medical services: nursing care, at home hospitals, at hospices, in critical condition

Medicare funded by taxes from all employees: from wage earners, employers (accounting for almost 15% of Americans' incomes), as well as from general income tax revenues [9]. The Medicare Advantage program - to control the costs of this system, as well as providing additional services to the insured, supplemented the Medicare program in 1997. In order to avoid abuse, in particular the overestimation of prices for medical services by medical personnel, a list of procedures with established prices introduced.

In addition, since January 1, 2006, the Medicare system supplemented with the Medicare Part D program, which involves a voluntary, private, subsidized coverage of medicine costs. The Medicare Part D program accepted as part of three programs: Medicare Prescription Drug (which regulates the provision of prescription drug drugs); Improvement, and Modernization Act of 2003 (IMA) and Medicare Part B (covering directly health insurance). According to these programs, part of the insurance contribution paid by the insured persons themselves to ensure the availability of payment for additional medical services and drugs not included in the main Medicare program. The cost of funding of the Medicare has been steadily increasing.

If in 2007, they made 440 billion USD or 16% of all federal expenses, then in 2008 – already 599 billion USD, or 20% of federal expenses. Such an increase in costs has become a constant pretext for initiatives to reform this program with significant changes [10]. Thus, one of the proposals was an obligation on the part of the federal government to buy health insurance for individuals to cover their health care costs [10].

The Medicaid program does not formally fall into the social insurance program, but is, first, social security and the protection of the poor. The federal government and state fund Medicaid jointly. Depending on the financial status of the state (income per capita), the percentage of participation in state spending varies ("rich" states finance about 50%, "poor" – less).

Each state manages its own Medicaid program (which may have its own name, for example: Medicaid in California, MassHealth in Massachusetts, Oregon Health Plan in Oregon, TennCare in Texas). The Federal Medicaid Service Center monitors state programs and sets requirements for providing quality services, provision, financing, and standards. The participation of American states in the Medicaid program is voluntary, but since 1982, all states have entered this program.

The United States government directly to service providers, while other states practice provides payment for health services in individual states subcontracting with private healthcare companies [10]. The main criterion for granting and the right to use Medicaid is the property of the applicant (the patient). Nevertheless, it is not possible to determine a specific list of qualifications, since each state has its own program, which is often very different from the others (although formed within the federal requirements). Under certain circumstances, any applicant may be denied access to the program.

In addition to having a limited income, the applicant applying for the program must belong to specific privileged categories of citizens according to the relevant criteria (age, pregnancy, disability, blindness, USA citizen status or legal immigrant, finding a home for the elderly, children with disabilities, HIV-infected, etc.). Consequently, poverty is not enough for getting Medicaid. In 2008, due to Medicaid, provided health services to approximately 49 million people with low incomes.

It consists on inhabitants of houses for the elderly (almost 60%), about 37% – patients of maternity hospitals. Medicaid in 2008 accounted for 57% of all USA health care costs [11]. The current state of the American healthcare system shows that there are some problems with the organization and funding of Medicare and Medicaid. The main problems of Medicare and Medicaid programs are increasing of costs on medical technology and medicines. Therefore, criticism of Medicare and Medicaid programs is becoming increasingly common, endangering their existence.

DOI: 10.5281/zenodo.2639521

Expanding the administrative and legal content of Medicare and Medicaid social programs, we should admitted that health care providers and health care providers have the right to choose whether to provide medical services to applicants or not. Since the rates of reimbursement for social programs, Medicare and Medicaid are lower than in the private insurance, more and more doctors do not participate in them. The most comprehensive coverage of the costs of regular, preventive, emergency medical services and the majority of prescription drugs provided by private health insurance.

Social, state and federal programs provide much less service. At the cost of private health insurance, 35% of the total cost of the USA healthcare system is funded (the largest share among the countries of the world). On average, in industrialized countries, the part of private health insurance in the total amount of health care costs is 10% [12]. In most cases, private health insurance funded by the employer and may be:

1) Compensative, so that the employer pays the insurance company a bonus for each employee provided with the corresponding policy. The insurance company pays checks sent by a multi-disciplinary hospital, another medical institution or doctor. In this case, the medical services provided by the insurance are paid. Other services paid by the patient;

2) Insurance of managed services provides for the insurance company concludes agreements with doctors, other medical workers, and medical institutions for the provision of all types of services provided for this type of health insurance. Medical institutions receive a fixed amount, which prepaid for each insured person.

In the case of compulsory healthcare insurance, only implemented medical services are paid, and then in the case of managed insurance, the medical institution receives a fixed amount for each patient, regardless of the volume and cost of services.

Consequently, in the case of compensation insurance, medical workers are interested in providing various medical services to patients, then, in the insurance of managed services, doctors refrain from appointing additional diagnostic or medical procedures and medicines. However, private insurance does not provide full compensation for medical and pharmaceutical costs. The market for private insurers in the United States is highly concentrated. Leading insurers have made more than 400 times the merger between the 1990s and the mid-2000s.

As a result, in 2000, the two largest insurance companies Aetna and UnitedHealth Group covered 32 million people. Moreover, already in 2006, two WellPoint and UnitedHealth companies provided insurance for 67 million people, or 36% of the national commercial medical insurance market. This fact is a concern in American medical associations, and the USA Department of Justice has recognized that such a concentration leads to monopsony (there are one customer and many sellers) in this market sector. Of course, this substantially limits the possibilities of medical institutions and doctors in a free choice of the insurer, and leads to the imposition of their conditions for contracts for the provision of medical and pharmaceutical services.

The situation when more than 15% of all Americans do not have insurance cover and, consequently, should pay medical and pharmaceutical services from their own pockets, which often leads them to bankruptcy, cannot be considered optimal. On the other hand, the insurance coverage of more than 50% of the contingent population of the United States depends on their employment status and employer. The possibility of a rapid loss of health insurance is a manifestation of instability in this area of public life.

Therefore, the talk about the necessary of reforming the health care system in the United States lasted for almost a century. In 1912, President Roosevelt and his progressive party promised the introduction of a national health insurance [13, 14].

In 1945, President of USA Truman proposed to introduce a system of national health insurance, within which would create a special Fund, which was supposed to pay all the necessary medical and pharmaceutical costs, as well as compensation for wages for the period of the disease. Participation in the Fund would be compulsory for all Americans, with each participant paying monthly contributions. Participation of providers of medical and pharmaceutical services (medical organizations, individual doctors, etc.) in the compulsory health insurance system provided voluntarily.

The influential American Medical Association (AMA) criticized that approach, accusing the developers of the program of implementing a socialist approach to the organization of health care in the country. March 8, 2010 President of the USA Barack Obama noted the following: "... health reform is more than just a moral imperative, it's a financial debt. If we want to create jobs and restore our economy, we must address the issue of healthcare ... "[15, 16].

In 2009, the American journal of the American Journal of Public Health published the study of Harvard University, according to those more than 44 800 deaths a year in the United States associated with the lack of insurance protection [1]. The benefits of the USA health care system for pharmaceutical provision of privileged population groups shown on a Fig. 1.

At the same time, there are a number of disadvantages given on a Fig. 2. Among them, the high cost, the limitation of the right to medical care and medicines (due to a significant number of people without American citizenship) are the main ones. Therefore, per capita costs in the USA make up about 7000 USD a year, which is more than twice of the average among industrialized countries. The high cost of medical services and medicines becomes a certain obstacle to the organization of health insurance and the potential cause of conflict between health insurance providers regarding the validity of accounts payable.

While analyzing the experience of building of a system of organization and financing of healthcare system in the United States, we conclude that it is possible to use such positive aspects of the American system as shown on a Fig. 3 for the reform of the healthcare sector in Ukraine:

DOI: 10.5281/zenodo.2639521

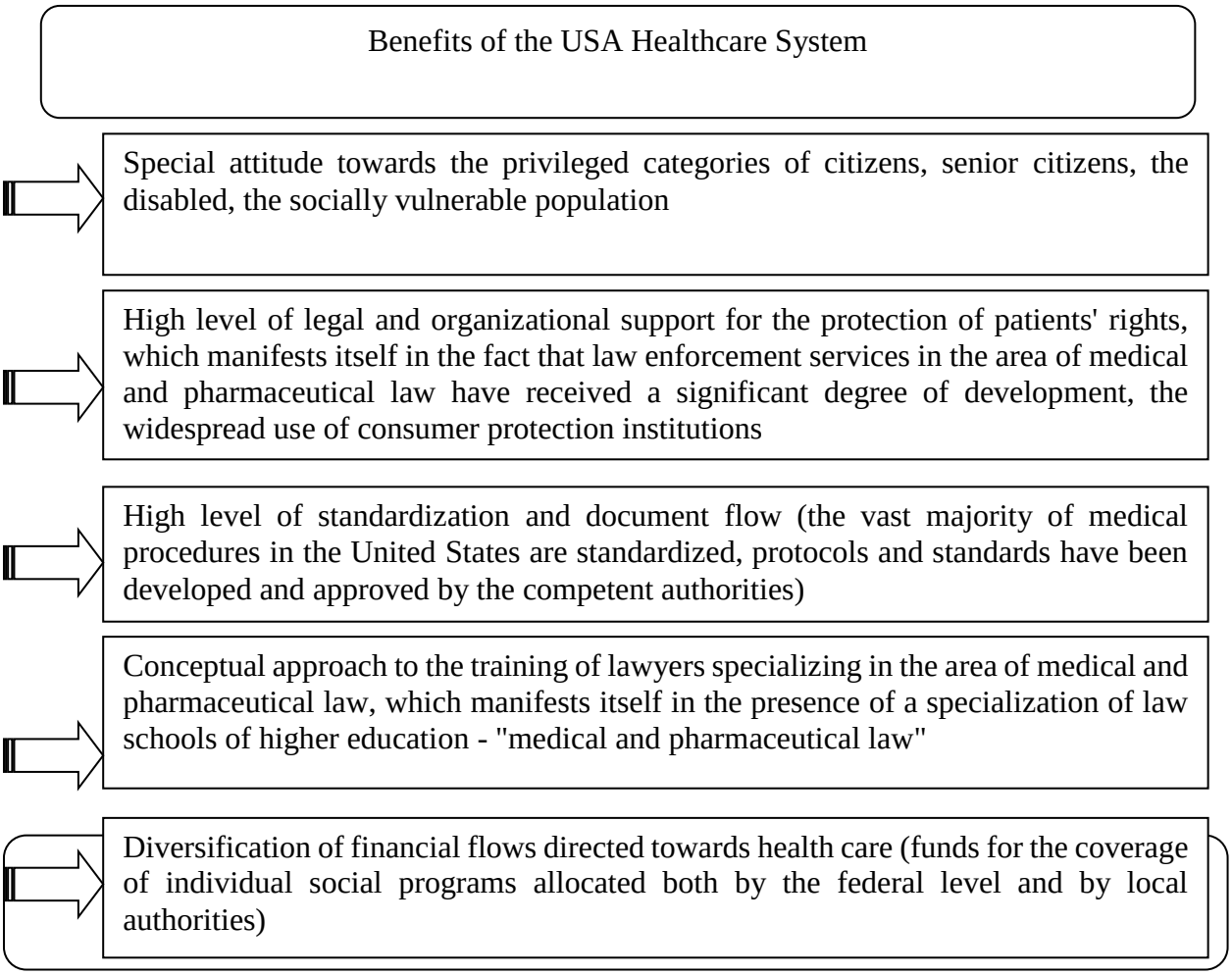

Figure 1. Benefits of the US Healthcare System for pharmaceutical provision of medicinal products to privileged population groups

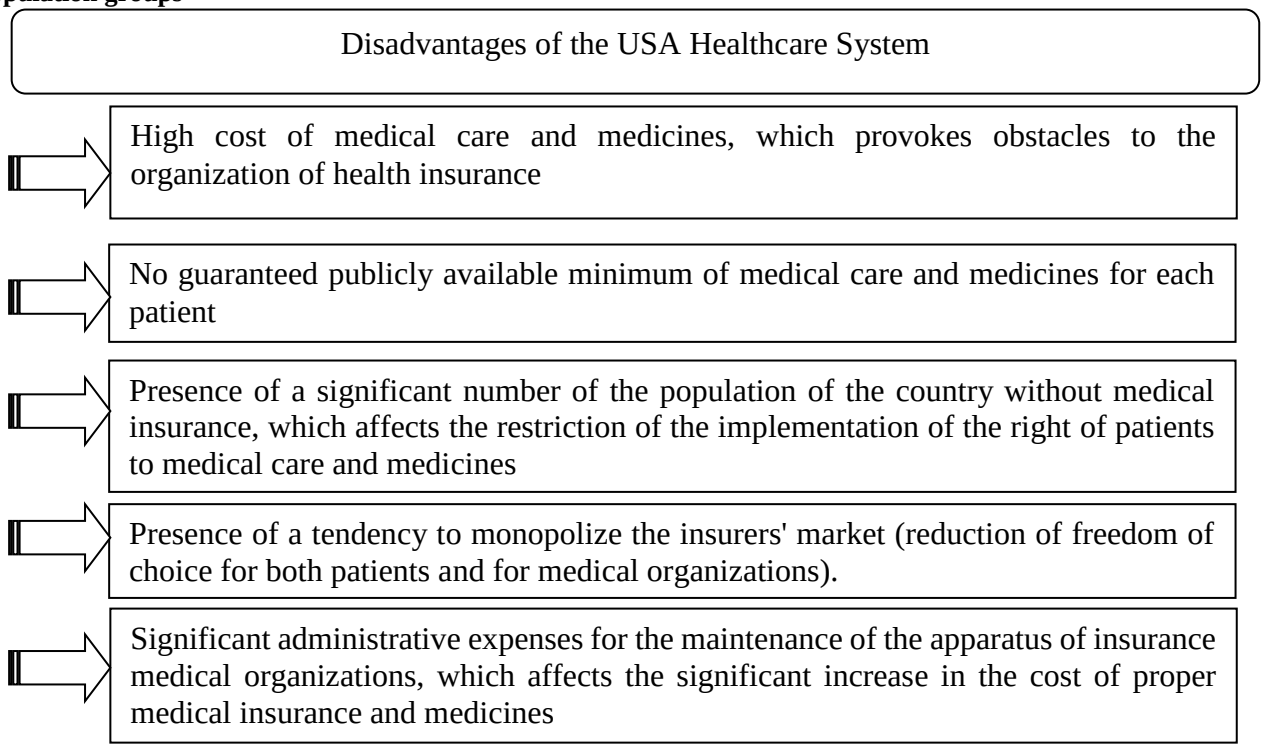

Figure 2. Disadvantages of the US Healthcare System for pharmaceutical provision of medicines to privileged categories of citizens

DOI: 10.5281/zenodo.2639521

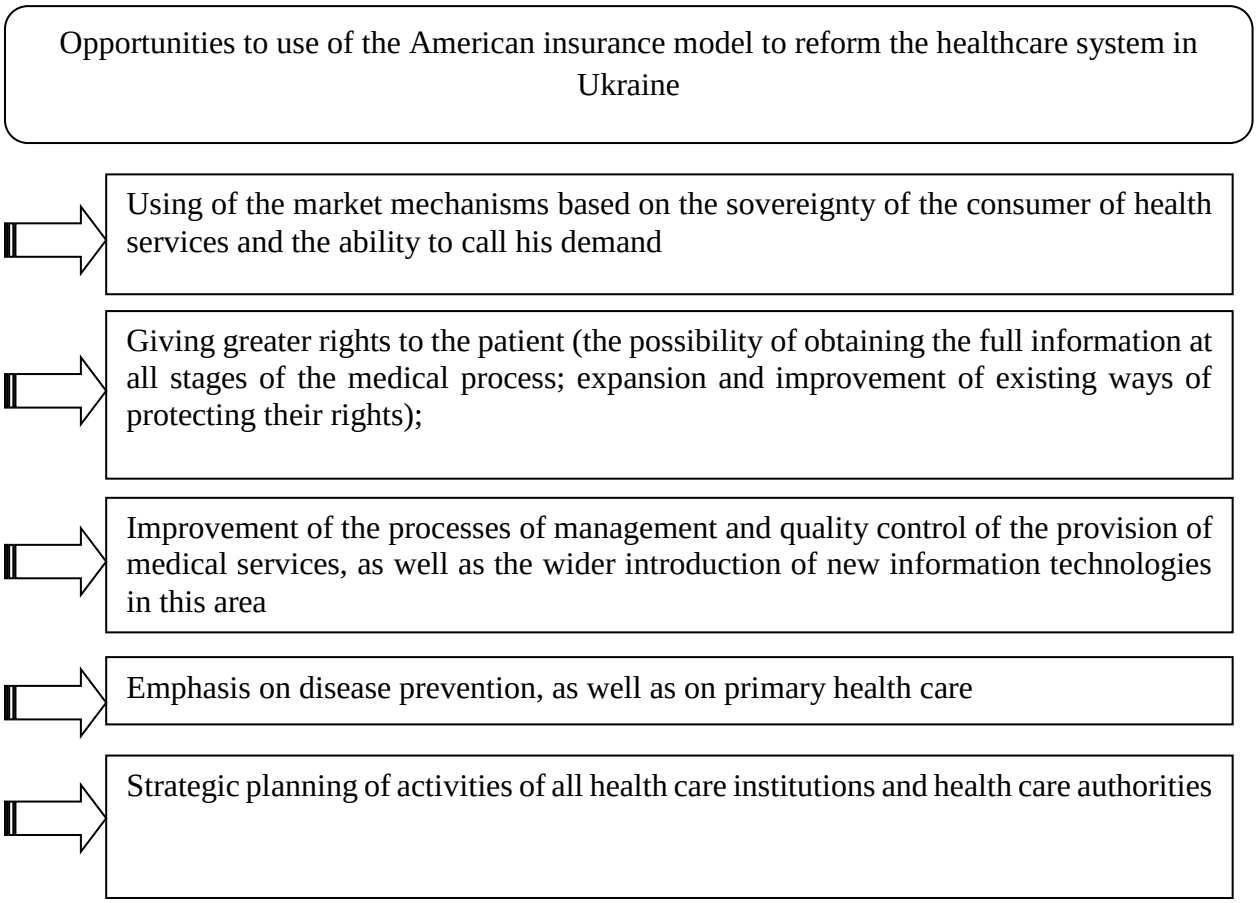

Figure 3. Opportunities to use the American insurance model to reform the health care system in Ukraine

On January 1, 2014, the Law on the Protection of Patients and Affordable Care Act (ObamaCare) entered into force in the United States of America, which fundamentally changed the health insurance system to reduce the cost of medical and pharmaceutical care (premiums) for every American. However, in practice, the cost of premiums in the 44 states increased by 30-50%, and in Vermont – by 144%. Only in five states (Colorado, New Jersey, New York, Ohio and Rhode Island), premiums have decreased.

The state of the healthcare system in the United States determined by the state of the hospital service. Obamacare radically changes the goals and methods of medical staff working. According to Obamacare, hospitals rewarded for the quality of care, but not for the number of patients. The main component of Obamacare are insurance market or exchange offices. Insurance market is an ordinary financial pyramid and, like all such structures, is very unstable. The basis of this pyramid is the young and healthy groups of population.

They rarely go to a doctor, but must buy offered insurance from the insurance market, those are only four types of insurance, approved by the federal government. Some insurance cover costs that not always needed by consumers. For example, the cost of "maternity protection". Lonely young man or spouse, who is about 60 years old, this cover is unlikely to be needed. However, a person cannot abandon it. Thus, Obamacare forces some people to subsidize a medical service that is not in need for them, but which requires other categories of the population.

Obamacare aims at redistributing people who rarely need doctor`s consultation to those who often need it. According to the Department of Health and Human Services in the United States of America, about 12 million adults under the age of 34 do not have insurance coverage. The distinctive feature of Obamacare was its opacity. Subsequently, the Texas Court of Appeal announced an unconstitutional healthcare reform Obamacare in the United States on December 14, 2018.

The main disadvantage of the healthcare system in the United States of America is the high cost of medical and pharmaceutical care. Per capita costs in the United States of America are 7,290 USD for a year that is more than 2 times higher than the average for industrially developed countries. However, the high level of legal and organizational support for the protection of patients' rights, which manifests on developing lawyers` services in the area of medical and pharmaceutical law, the prevalence of the institutions involved in the protection of consumers' rights, the particular attitude towards the privileged categories of citizens, the senior citizens, the disabled and some other categories of socially disadvantaged sections of the population are unconditional benefits in providing health care in the United States of America.

Thus, the USA experience suggests that introducing private health insurance, as the main source of funding is not feasible, as there may be serious financial disproportions in health care.

Conclusions from the conducted research and prospects of further development of this direction

DOI: 10.5281/zenodo.2639521

Reforming the health care system of Ukraine for the organization of pharmaceutical provision of privileged categories of citizens requires careful analysis of the experience of the advanced world countries.

The analysis of the USA experience in organizing of health care system has revealed positive and negative aspects that need to take into account for reforming the system for the provision of medicines and medical services in Ukraine.

The main advantages of the American model of the healthcare organization are determined, among them the availability of strategic planning of the activity of healthcare institutions; introduction of modern information technologies; protection of patient's rights; priority attention to the prevention of diseases; the desire to achieve the highest possible level of provision of medical and pharmaceutical services at moderate financial costs.

The insufficiency of the health insurance system noted, which has led to the recognition of Obamacare's health system unconstitutional in some states.

The necessity of preserving public administration in the healthcare system in Ukraine for pharmaceutical provision of privileged categories of citizens substantiated. Obligatory health and social insurance must play a supporting role in financing healthcare system.

References

1. Stetsenko V.Yu. Organizational and legal provision for medical insurance in the USA / V.Yu. Stetsenko [Online]. - URL: http://irbis-nbuv.gov.ua/ [Accessed on: 15 March 2019].
2. Gomon D.O. Foreign experience in providing of healthcare. Scientific herald of Kherson State University. 2016. 4. T. 1. P. 123-126
3. Kazzi N. More Americans losing health insurance every day. Analysis of health coverage losses during the recession / N. Kazzi // Centre American progress. – 2009. – May 4. cgibin/irbis_nbuv/cgiirbis_64.exe?C21COM=2&I21DBN=UJR N&P21DBN=UJRN&IMAGE_FILE_DOWNLOAD=1& Image_file_name=PDF/pp_2013_4_6.pdf
4. Wilper A. P. Health insurance and mortality in USdults / A. P.Wilper, S.Woolhandler, K. E. Lasser, D. McCormick, D. H. Bor // American journal of public health. – December 2009. – Vol. 99. – № 12. – P. 2289-2295.
5. Official site of the Organization for Economic Cooperation and Development [Online]. - URL: http.www.oecd.org [Accessed on: 24 February 2019].
6. DeNavas-Walt C. Income, poverty and health insurance coverage in the United States, 2007 / C. DeNavas-Walt, B. D. Proctor, V. C. Smith. – US Census Bureau, 2008. – 84 c.
7. Staman J. Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis / J. Staman, C. Brougher // CRS Report for Congress – Congressional Research Service. – 2009. – 24 July. – P. 1-18.
8. Baeva O. V. Management in the field of health: [curriculum vitae manual] / O.V. Baeva. - K.: Center for Educational Literature, 2008. - 640 p.
9. Potetz L. Financing Medicare: an issue Brief / L. Potetz. – Washington : The Henry J. Kaiser Family Foundation, 2008. – 17 p.
10. The World Health Report 2000 – Health systems: Improving performance : [Online]. – URL: http://www.who.int [Accessed on: 27 February 2019].
11. OMB Home White House Website: [Online]. – URL: http://www.whitehouse.gov [Accessed on: 03 March 2019]..
12. Boerma T. World health statistics 2010 / T. Boerma, C. AbouZahr. – France : WHO Library Cataloguing-in-Publication Data, 2010. – 177 c.
13. Roosevelt T. Roosevelt's own creed set forth / T. Roosevelt // The New York Times. – 1912. – August 7.
14. Remarks by the President to a joint session of Congress on health care: [Online]. – URL: http://www.whitehouse.gov/the_ press_office [Accessed on: 12 March 2019].
15. Yamey G. Obama's giant step towards universal health insurance / G. Yamey // BMJ. – 2010. – 24 March. – P. 340-344.
16. Pear R. Obama hails vote on health care as answering the «call of history» / R. Pear, Herszenhorn DM. // New York Times. – 2010. – March 21.

EXPERIENCE OF THE USA CONCERNING AN ORGANIZATION OF HEALTHCARE SYSTEM FOR PHARMACEUTICAL PROVISION FOR PRIVILEGED CATEGORIES OF CITIZENS

Shapovalov V.V. (Jr.), Gudzenko A.O. , Andrieieva V.V., Shapovalova V.O., Shapovalov V.V.

Introduction. Nowadays there is no ideal healthcare system for medical and pharmaceutical provision for privileged categories of citizens in the world. Healthcare systems for medical and pharmaceutical provision for different categories of population of every country, which are the result of historical conditions and economic development, are continuously reformed.

Economic approaches to planning of healthcare and pharmaceutical provision as a commodity system threaten the adverse impact on a health of privileged categories of citizens and the functioning of the healthcare system in general. Thus, the best approach is to learn the experience of other world countries in reforming of the healthcare system for medical and pharmaceutical provision for privileged categories of citizens, with a constant assessment of the changes, that taking place and readiness to adapt the system to changing external conditions, with the obligatory observance of all ethical requirements

Materials and methods. Conducted a retrospective analysis of healthcare system reform, which applied in the USA during the period from 2000 to 2018. During a research used the following methods of analysis: normative and legal, documentary, comparative. **Results and discussion.** The United States of America is practically the only country in the world with a developed economy where there is no publicly available medical care. According to the WHO, the American health system ranked 37th out of 191 countries by the level and effectiveness of overall healthcare, although USA healthcare costs are 15.7% of gross domestic product. The United States, with its global leader, leading economies,

DOI: 10.5281/zenodo.2639521

annual budget, several times the budget of any other state, cannot provide the appropriate level of provision and availability of medical care and pharmaceutical provision for the population and its privileged contingents. In addition, part of the USA public spending in total healthcare costs is only 45%, much lower than in any other country of the Organization for Economic Cooperation and Development. That is why there is a need to analyze of healthcare system of the USA and the realization of the rights of the privileged categories of citizens for getting quality medical care and the provision of medicines. The main sources of financing of the American health system are private and non-commercial insurance, which covers approximately 85% of the population (about 50% are insured by their employers, 10% are self-insured, the rest are insured under the state programs). In addition to having a limited income, the applicant applying for the program must belong to specific privileged categories of citizens according to the relevant criteria (age, pregnancy, disability, blindness, USA citizen status or legal immigrant, finding a home for the elderly, children with disabilities, HIV-infected, etc.). The main disadvantage of the healthcare system in the United States of America is the high cost of medical and pharmaceutical care. Per capita costs in the United States of America are 7,290 USD for a year that is more than 2 times higher than the average for industrially developed countries. However, the high level of legal and organizational support for the protection of patients' rights, which manifests on developing lawyers` services in the area of medical and pharmaceutical law, the prevalence of the institutions involved in the protection of consumers' rights, the particular attitude towards the privileged categories of citizens, the senior citizens, the disabled and some other categories of socially disadvantaged sections of the population are unconditional benefits in providing health care in the United States of America. **Conclusions.** The analysis of the USA experience in organizing of health care system has revealed positive and negative aspects that need to take into account for reforming the system for the provision of medicines and medical services in Ukraine. The main advantages of the American model of the healthcare organization are determined, among them the availability of strategic planning of the activity of healthcare institutions; introduction of modern information technologies; protection of patient's rights; priority attention to the prevention of diseases; the desire to achieve the highest possible level of provision of medical and pharmaceutical services at moderate financial costs. The necessity of preserving public administration in the healthcare system in Ukraine for pharmaceutical provision of privileged categories of citizens substantiated. Obligatory health and social insurance must play a supporting role in financing healthcare system.

Keywords: USA, organization of healthcare system, pharmaceutical provision, medicines, privileged categories of citizens.

DOI: 10.5281/zenodo.2639521