МРНТИ 06.71.47
JEL: H51, H52, I12, I15
https://doi.org/10.58732/2958-7212-2022-4-6-20

Evaluating the Effectiveness of Health Care Systems: Foreign Experience

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Abstract

Purpose of the work to analyze the features of the formation and functioning of the healthcare model and to summarize the experience of applying various methods of managing healthcare systems in developed and developing countries. Research method: descriptive research methods, analogy methods, groupings, scientific factual, systematic, comparative and retrospective analysis are used as instrumental methodological methods for studying the problem, but general scientific research methods (derivation, deduction, collection and processing of statistical information). This provides a basis for comparing the development of public health management tools applied in foreign countries. Analyzing the directions of development of health care systems in developed and developing countries, we find that, depending on the existing health care system, the goals, objectives and mechanisms of development can be similar or differ greatly. The search for the best model, carried out in both developed and developing countries, makes it impossible to create a unified approach to building a health care system that will ensure the creation of the most effective health care system. The effectiveness of the functioning of health care systems and the achievement of the goals set to improve people's health are less related to the implementation of specific management activities but are related to the socio-economic conditions of management. Their implementation and the existing healthcare system. This is confirmed by the similar rates of increase in life expectancy at birth in developed countries, despite significant differences in management tools and a natural difference in management tools.

Keywords: health care, model, health insurance, Semashko system, private health care system, foreign experience

Денсаулық сақтау жүйесінің тиімділігін бағалау: шетелдік тәжірибе

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Түйін

Зерттеу әдісі мәселені зерттеудің аспаптық әдіснамалық әдістері ретінде сипаттамалық зерттеу әдістері, аналогиялық әдістер, топтастырулар, ғылыми фактілік, жүйелік, салыстырмалы және ретроспективті талдаулар қолданылады, бірақ жалпы ғылыми зерттеу әдістері (статистикалық ақпаратты шығару,

дедукциялау, жинау және өңдеу). Бұл шет елдерде қолданылатын қоғамдық денсаулықты басқару құралдарының дамуын салыстыруға негіз болады. Дамыған және дамушы елдердегі денсаулық сақтау жүйесінің даму бағыттарын талдай отырып, біз қолданыстағы денсаулық сақтау жүйесіне байланысты дамудың мақсаттары, міндеттері мен механизмдері ұқсас немесе айтарлықтай ерекшеленетінін байқаймыз. Дамыған елдерде де, дамушы елдерде де жүргізілетін ең жақсы үлгіні іздеу денсаулық сақтаудың ең тиімді жүйесін құруды қамтамасыз ететін денсаулық сақтау жүйесін құрудың бірыңғай тәсілін құруды мүмкін емес етеді. Денсаулық сақтау жүйелерінің қызмет етуінің тиімділігі және адамдардың денсаулығын жақсарту бойынша алға қойылған мақсаттарға жету нақты басқару қызметін жүзеге асырумен аз байланысты, бірақ басқарудың әлеуметтік-экономикалық жағдайларымен байланысты. Оларды жүзеге асыру және қолданыстағы денсаулық сақтау жүйесі; Басқару құралдарының айтарлықтай айырмашылығына және басқару құралдарының табиғи айырмашылығына қарамастан, дамыған елдерде туылған кезде күтілетін өмір сүру ұзақтығының ұлғаюының ұқсас қарқындары мұны растайды.

Түйін сөздер: денсаулық сақтау, үлгілер, медициналық сақтандыру, Семашко жүйесі, жеке денсаулық сақтау жүйесі, шетелдік тәжірибе

Оценка эффективности систем здравоохранения: зарубежный опыт

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Аннотация

Цель работы проанализировать особенности формирования и функционирования модели здравоохранения и обобщить опыт применения различных методов управления системами здравоохранения в развитых и развивающихся странах. Метод исследования: описательные методы исследования, методы аналогии, группировки, научно-фактический, систематический, сравнительный и ретроспективный анализ используются как инструментальные методологические приемы изучения проблемы, но общенаучные методы исследования (деривация, дедукция, сбор и обработка статистической информации). Это дает основание для сравнения развития инструментов управления общественным здравоохранением, применяемых в зарубежных странах результат. Анализируя направления развития систем здравоохранения в развитых и развивающихся странах, мы обнаруживаем, что в зависимости от существующей системы здравоохранения цели, задачи и механизмы развития могут быть схожими или сильно различаться. Поиск наилучшей модели, осуществляемый как в развитых, так и в развивающихся странах, делает невозможным создание единого подхода к построению системы здравоохранения, который обеспечит создание максимально эффективной системы здравоохранения. Эффективность функционирования систем

здравоохранения и достижение поставленных задач по улучшению здоровья людей в меньшей степени связаны с реализацией конкретных управленческих мероприятий, а связаны с социально-экономическими условиями ведения. Их внедрение и существующая система здравоохранения; Это подтверждается сходными темпами увеличения ожидаемой продолжительности жизни при рождении в развитых странах, несмотря насущественные различия в инструментах управления естественное различие в инструментах управления.

Ключевые слова: здравоохранение, модель, медицинское страхование, система Семашко, частная система здравоохранения, зарубежный опыт

Introduction

During the last decade countries have been paid special attention to the issues of the quality of life of the population in the implementation of the current state policy and planning the country's strategic development. This situation actualizes the issues of increasing the efficiency public administration in this area, which requires the use of adequate methods evaluation of the effectiveness of the implemented policy, considering regional specifics and domestic and foreign experience in this area. In the world, there are a huge variety of specific forms of organization of the public health system, established under the influence of economic, political, cultural, historical, moral and ethical factors, and a similar level of socio-economic development does not always mean a similar similarity in healthcare systems. For example, developed countries use various models of medical systems: liberal (USA), corporate (Japan), social democratic (Scandinavia), etc. At the same time, the evolution of healthcare systems shows that under the influence of globalization, on the one hand, the role of market mechanisms is increasing On the other hand, control by the state and (or) international organizations is being strengthened. This is manifested in the fact that insurance financing is becoming more widespread, competition between health care providers is encouraged, and population coverage is growing countries with medical care, international quality standards are being introduced.

According to the WHO, a health system is a collection of resources, organizations, and institutions that share a common goal of improving the health of all individuals. It includes everyone from the doctor in a hospital in the capital city to the family in a rural village. The system also encompasses nutrition and sanitation, and it operates within various government agencies, for-profit organizations, and civil society.

The goal of a health system is to provide the best possible care to all its members. It starts with the parents, who are knowledgeable about how to keep their kids healthy. If a child gets sick, the mother can take the child to a clinic, where the doctor will diagnose and treat the issue correctly. The clinic will also have the necessary equipment and resources to provide the best possible care.

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Literature review

Consider the specific features of the formation and functioning of models health care. Depending on the methods of financing, forms and methods of controlling the volume and quality medical care, incentive mechanisms for providers and consumers of medical services distinguish three main models of the health care system: Bismarck (insurance); Beveridge (state); Semashko (which is a kind of state system) and private [1]. The first three models are built on the premise that a person's access to medical services does not depend on his well-being: the rich pay for the poor, the healthy pay for the sick.

In the private model, medical services are treated like any other commodity. Currently, there is no single, most effective model of the health care system, which leads to the need for reforms even in countries with high indicators of public health and living standards.

The health insurance system is the most widely used in the world practice. (Bismarck). Having a decentralized nature of management (at the regional level), the system Bismarck is financed from three sources: insurance premiums from enterprises, subsidies from the state and the costs of the insured himself. The payments of the population and enterprises are of dominant importance in the financing of the system. Government spending mainly consists of payments for the non-working population, as well as financing of socially significant types of care and targeted programs (e.g. mental health care where treatment is patient can take up to several years, which is very unprofitable for insurance companies and, usually not included in standard household insurance).

In countries with a health insurance system, there are generally two types medical insurance: compulsory medical insurance (CMI) and voluntary medical insurance (VHI).

It should be noted that the targeted nature of the financing of the Bismarck system allows to respond more flexibly and quickly to expanding needs for medical services. It offers the population a wide range of insurance companies, medical organizations and

services they provide, and medical and nursing staff. Competition between organizations (insurance and medical) contributes to improving the quality of medical care. The Bismarck system implies a clear distribution of functions and responsibilities between the state, funding bodies and medical institutions, together with

However, in our opinion, it has a number of problems:

- Unequal access to medical care for various social groups and remote territories;
- unjustified increase in the cost of medical services;
- Insufficient consideration of the interests of patients who are included in high-risk groups, who are in a hospital for a long time or who remain outside the social insurance system;
- VHI violates the principle “the rich pay for the poor, the healthy pay for the sick”

As an example of the successful functioning of Bismarck's healthcare system consider the German experience. Most experts agree that the German healthcare system is one of the most efficient in the world and continues to improve constantly [2].

However, the main problem of German healthcare has been and remains the high cost of medical services and pharmaceuticals. Concerning the German government is actively reforming the health care system two directions.

As part of the first direction in the early 2000s, the following were carried out: optimization expenses for medical services; various benefits have been introduced (for children under 18 there are no additional payments); introduced an electronic card containing medical data on human, which avoids the need for repeated studies. The Institute for the Quality and Economic Efficiency of Health Care was established. The Institute analyzes the therapeutic effects of drugs, creates clinical recommendations for the treatment of diseases, engages in research activities on the quality and financial rationality of services, and also provides the public with information on the quality and effectiveness of work of healthcare systems. This innovation allows Germany to save up to 3.3 billion euros per year [3]. As part of the second direction, the list of compensated medicines and provided an opportunity for pharmacists to set the cost of medicines.

An example of the implementation of the Bismarck health care system is the experience of Bulgaria. Prior to the introduction of the insurance system in Bulgaria, the state model of healthcare functioned. The goal of the transition to insurance medicine was to create an effective and responsive the needs of the patients of the system, however, the introduction of the insurance principle did not give the expected result. The system of financing based only on insurance premiums has failed to provide sufficient funds - about a million people have refused to participate in the universal compulsory medical insurance program, which led to the fact that those who make contributions to health insurance are fewer than those who use the benefits provided by them [4]. This prompted the government to new reforms: the legalization of private practice and its participation in the MHI system, the restructuring of the primary health care sector, the introduction of the institution of general practitioners, as well as the use of clinical examination algorithms and treatment. Currently, the Bulgarian government is also pursuing an active policy to reforming the health care system, aimed at achieving the indicators of the most developed European countries and convergence with the European Union system: an effective implementation of the legislation of the European Union and the development of funds from the European Union.

The funds of the European Union are planned to be invested in health care and directed to increase in efficiency and restructuring of the hospital network, as well as the development of labor resources.

The main directions of the reform (the health care system in Bulgaria has been developing in recent years according to the "National Health Strategy for 2007–2012") have become standardization (in this direction, the system of accreditation of medical institutions and the development of standards have been improved; payment for the services of institutions depends on the quality of the medical care they provide) and healthcare informatization (in Bulgaria, a lot of efforts are being made to create electronic medical records, which make it possible to work electronically with referrals for treatment and examination, as well as prescriptions), which has yielded significant results both in the medical and financial aspects [5] . New health strategy for the period 2014–2020 focused on solving individual problems, such as regional inequality, a shortage of specialists in the industry, the fight against corruption; special attention is paid to

intersectoral cooperation and participation of citizens in the management of the system (achieving a broad social and political consensus). Critics of this strategy note that it does not include specific measures to achieve the stated goals [6]

The public health system (Beveridge, Semashko systems) is also represented both in developed countries (Great Britain, Canada) and in developing ones.

The main characteristics of the public health system are:

- central and regional planning (when planning medical care central planning has an advantage, despite the fact that the peculiarities of the development of regions are also taken into account. The health care system is managed centrally through the highest governing body of the health care system);
- Financing health care through direct taxation (all funds are formed, as a rule, in the federal budget and distributed from top to bottom along the administrative vertical. Such centralized financing allows growth to be controlled cost of medical services);
- quality control of medical services by the state;
- coverage of medical care for the entire population (the state system ensures the equality of citizens in receiving medical care. With such a system, the main part medical institutions are owned by the state).

The state provides training for medical personnel, plans to develop a network medical organization, finances the current and investment costs of the healthcare system, develops medical science, carries out preventive measures and provides free medical care to the population.

Among the main problems characteristic of the public health system are:

- insufficient stimulation of medical organizations to improve their efficiency;
- centralized containment by the state of growth in health care spending;
- insufficient consideration of the patient's opinion when choosing a doctor and medical institution;
- turn - the regulator of the provision of medical care, in connection with which the provided
- population groups prefer to go to private practitioners;
- Insufficient choice of hospitalization conditions from the point of view of the patient

The UK was one of the first countries to introduce a state system healthcare. Since 1911, the UK had a health care system that covered about 1/3 of the population, and in 1948 a universal, free service was established health care (National Health Service, or NHS) [7]. Since its inception, the state system has had an important distinctive feature, which has been preserved to the present, is the payment of “general practitioners” by the per capita method (capitalization). This is a payment method where the budget received by one private practice depends primarily on the number of patients registered on a permanent basis. Thus, the basic principle of capitation is that money follows the patient.

In this case, they have the opportunity to partly regulate demand according to the laws of the free market, as they have the right to freely choose a doctor [8]. Today, annually received by a doctorgeneral practice in the UK the amount depends on the number of patients who have registered as his patients, on their sex and age and social status.

This is a fundamental feature of the health care system, around which, for the most part, all reforms during the twentieth century. After the establishment of universal free health care, a serious moral hazard arose: since general practitioners funded by the state, patients who no longer paid for their treatment became abuse medical services, i.e. use them without real grounds. Multifold increase in government spending on health care led to the introduction of co-payments patients. In order to manage the risks associated with nosologies that require serious expensive treatment, doctors were allowed to unite in groups of fund-holders, and competition remained between groups of doctors. This system structure health care allowed the UK to spend almost half as much on relation to GDP in comparison with other highly developed countries [8].

However, over time, government spending on health increased (critics of the NHS attributed this to the increasing costs of administration and bureaucracy). The content of the NHS in the UK began to be spent up to 17% of the state budget [9], which, together with the aging of the population, has led to the need to reform the healthcare system.

The main directions of the ongoing reform are the reduction of administrative costs and more active participation of the private sector of medicine in the provision of services to the population.

The first direction involves changing the funding model and the role of the doctor in German Before the reform, the main distributive function was performed by the managers of the regional departments of the health care system (trusts). The funds were used for planning and payment for medical services. According to the reform, this function should move to groups of clinical orders consisting of physicians.

The second direction of the reform is to increase the volume of medical services provided by private organizations, which should lead to increased competition and cost reduction [10]. Among developed countries, the public health system is also represented in Denmark.

The Danish healthcare system provides free medical care to the entire population of the country (except for dentistry and physiotherapy, for which patients pay co-payments) and has its own unique distinctive features, formed, among other things, by the reforms of the last decade [11].

One of these features is the patient's freedom to choose a healthcare institution. The patient, having an appointment from a general practitioner, can choose to be admitted to any public hospital. In 2002, this right was extended and the patient, waiting for treatment for two or more months (since 2007 - one month), could also choose from some private and foreign clinics. However, the number of patients using the data right, insignificantly, since usually the duration of waiting for hospitalization does not exceed established norms.

Another feature is the payment of a part of medical care by clinical and statistical groups (the main part is paid for by block budgets).

Directions for reforming the Danish healthcare system include the standardization of treatment methods and the accreditation of healthcare institutions, carried out to improve the quality of medical services provided. Currently, the hospital infrastructure is being reorganized with an increased role of emergency care and a decrease in the number of hospital admissions, and the system of interaction between municipal, private and regional providers of medical services is being improved [12].

An example of a public health system among developing countries is Kazakhstan.

In 1991, Kazakhstan inherited the Soviet health care model, which was characterized by government regulation and central planning; one of the fundamental principles of the system were universal and free access of the population to medical care [13]. Major changes in the structure and regulation of the health care system took place in the 1990s and included: attempts to transfer management powers to regional authorities, the introduction of compulsory health insurance, and the restructuring of the primary health care sector.

Unfortunately, these reforms cannot be called successful. Currently, the system of providing medical services is still quite fragmented and does not fully ensure the continuity of medical care. Financing of health care is formed from two sources: the state budget (republican and regional) and personal payments of citizens. Budgetary health care financing was reintroduced in Kazakhstan in 1999 after an unsuccessful attempt to introduce a system of compulsory health insurance [14]. There is no clear interaction between primary and secondary health care, many services are provided by several parallel structures: for example, both anti-tuberculosis and sanitary-epidemiological services, as well as departmental systems health care at various ministries and departments. Weak horizontal integration leads to duplication of functions and inefficient use of healthcare resources.

The State Program for the Development of Healthcare of the Republic of Kazakhstan for 2011–2015 aimed at solving these and other problems. Within the framework of the program, it was supposed to strengthen the interaction of various healthcare structures, improve the financing system, as well as develop preventive services and improve the equipment of medical organizations [15].

It should be noted that the State Health Development Program Republic of Kazakhstan for 2016–2019 it is again planned to create a system of compulsory social health insurance in the country [16]. Further development of the healthcare system involves the formation in 2017 of a three-tier system for providing medical care, where responsibility for the health of citizens is shared between the state, employers and employees. At the same time, the first level represents a basic package or a list of state-guaranteed medical care, financed by republican budget (GOBMP); the second level will include additional a package or list of medical care determined by the Government of the Republic of Kazakhstan and financed by compulsory insurance payments from the state, employers and workers; the third level will provide for an individual package or list of services, determined on a voluntary contractual basis between insurance companies and payers of premiums financed by voluntary contributions from citizens or employers in favor of their employees.

With a private healthcare system, there is no mechanism for influencing the territorial distribution of medical services (money is distributed only to those territories that bring financial benefits to the budget), the state has insufficient control over the activities of medical institutions, lawsuits are widely used to control the medical and service provided to the population. services. Under this healthcare system, “imposition” of unnecessary medical services is noted, since the ratio of supply and demand is inadequate - demand is significantly lower than supply.

Such a health care system is subject to the interests of the market, in which medical

service is a commodity.

The most striking private health care system is represented in the United States, where two types of private health insurance are used: individual and group, which are funded by the state, personal funds of the population and insurance companies.

By the end of the 2000s, 74% of workers and employees of the private sector of the economy and 80% of the public sector [17]. At the expense of funds group insurance covers 2/3 of all medical services. Most American firms tend to provide collective insurance to their workers and employees. 13% of the population have both personal insurance and employers' insurance [18]. Small enterprises can pay only part of the health insurance of their employees. Many companies prefer to pay insurance amounts for employees not constantly, but only when treatment is necessary, therefore, in the event of dismissal, the employee turns out to be uninsured. VMI pays up to 30% of all medical services, including including hospital and out-of-hospital medical care.

Publicly funded programs: Medicaid - insurance for people with low incomes (in 2008, the number of insured people was about 58.8 million people) and compulsory social insurance for the elderly and people who have lost their ability to work - Medicare (in 2010, about 47.5 million people were covered by this program, of including 39.6 million people over 65 and 7.9 million people with disabilities) [19].

One of the main problems of the private healthcare system is the high cost of medical care and the low priority of preventive work, the lack of equal access to medical care for the population of various social groups and insufficient attention to patients receiving medical care at the expense of the state financing. In the late 2000s, US healthcare spending exceeded 14% from GNP, while the health indicators of the country's population were relatively not high, and 15% of the population were not able to use health care services [20].

These problems led to the need for significant reform of the system healthcare, which began in 2010 and made significant changes to the organization medical care to the population. The current U.S. health care reform is progressing according to the law “On the Protection of Patients and the Accessibility of Medical Care” [21], which includes four main areas of reform.

The first direction of the reform is the mandatory health insurance for all population. Now every resident of the United States is required to be insured. However, for various groups of the population (the poor, young people, etc.) and employers are provided with certain benefits. Before the reform, insurance was optional and the amount of medical services provided depended on a person's income or the willingness of his employer to pay a certain amount for insurance.

The second direction of the reform is the regulation of insurance rates and volumes medical care provided by insurance. Insurance companies are no longer eligible deny or prioritize (different costs) for different populations. The state also determines the basic insurance package, which includes disease prevention and diagnosis, outpatient drug coverage, long-term care, and inpatient treatment. The reform sets a limit on the co-payments of the insured person per year. The reform also established the ratio of funds of insurance companies, which should be directed to the treatment of patients, and their own income.

The third direction of the reform was the simplification of the choice of an

insurance plan by citizens: a special exchange has been created where you can get advice (on the Internet or by phone) and choose the right insurance plan for you.

Finally, the fourth direction of the reform is the regulation of prices for medical services and the improvement of their quality: commissions are being created that will assess the effectiveness of treatments, as well as insurance companies and private doctors.

Despite the high cost of the reform, the US government views it as cost-effective in both direct and indirect costs. Total cost of reform is about 940 billion dollars. Over 10 years, however, due to a decrease in the cost of medical assistance is expected to reduce the US federal budget deficit by $1 trillion [22]. Also, a positive effect from the implementation of the program will be a decrease in morbidity and population mortality.

Results and discussion

Summarizing the analysis of the directions of development of health care systems in developed and developing countries, we can conclude that the goals, objectives and mechanisms of development can be both similar and significantly different, depending on the existing delivery system medical care. The search for an optimal model, which takes place both in developed and developing countries, is associated with the impossibility of creating a unified approach to building health care system, which would ensure the creation of the most effective system providing medical care. Comparison of advantages and disadvantages of different systems health care is presented in Table 1

Table 1 - Comparative characteristics of health systems

System health care	Advantages	Disadvantages
Insurance	− wide coverage of the population medical care; − distribution of the financial burden on health care between the state and − the private sector; − high quality medical services associated with − the possibility of choosing an insurer by the population	− lack of equal access to medical care for various social groups and remote territories; − Tendency towards unjustified growth in the cost of medical services; − insufficient consideration of the interests of patients included into high-risk groups, long-term hospital or left outside the system of social insurance; − the existence of private insurance violates the principle "The rich pay for the poor, the healthy pay for the sick"
State	− complete coverage of the population medical care; − broad regulatory capabilities; − a wide range of tools for the implementation of plans	− Insufficient incentives to increase efficiency medical services and public services; − Central government restraint of growth health care spending; − Insufficient consideration of the patient's opinion when choosing doctor and medical institution;

		− turn - the regulator of medical care, in connection with which the wealthy groups of the population prefer to turn to private practitioners; − Insufficient choice of hospitalization conditions
Private	− competition leads to improving the quality of medical services; − The high cost of medical care increases importance of independent taking care of your health population	− high cost of medical care; − low priority of preventive work; − lack of equal access to medical care for the population of different social groups; − there is no mechanism of influence on the territorial distribution of medical services; − there is an "imposition" of unnecessary medical services, since the demand for medical services is not in fully complies with the offer

The healthcare systems existing in the world practice have their own specifics, which confirms the absence of universal methods of management. However, in developed countries (except Denmark) the state policy in the field of health care is directed, on the one hand parties, to optimize the cost of medical services and medicines, regardless of the one who pays for these services - the state (Germany, Great Britain) or the population (USA), on the other hand, the priority areas are: advanced training of medical personnel, development of a competitive environment, population co-payments and improvement of the quality of medical services and standardization.

In developing countries (Bulgaria, Kazakhstan), the state policy in the field of health care is aimed at developing the resource base of health care, improving the quality of medical services, and restructuring the network of institutions.

Conclusion

The above analysis shows a significant difference in both financial and organizational mechanisms and tools for the implementation of state policy in the field of healthcare. At the same time, the main goal of the health care system of any country is maintaining and strengthening the health status of the population. The most informative indicator of the state of health, and hence the achievement of the set goal, is the life expectancy of men and women at birth in the analyzed countries (Table 2).

Table 2 - Dynamics of life expectancy birth, years

Country	1990 year		2013 year		2021 year		Rate of increase (2021-2013 y.)	
	Man	Woman	Man	Woman	Man	Woman	Man	Woman
Germany	71.9	78.4	78.3	83.1	81.88	84.14	0.4	1.25
United Kingdom	72.9	78.3	78.6	82.5	81.77	83.28	0.4	0.94
Denmark	72.4	77.9	77.3	81.5	81.40	83.27	0.5	0.2
USA	71.7	78.6	76.5	81.3	79.11	81.65	0.3	0.4

Bulgaria	68.2	74.8	70.0	73.3	75.49	79.06	0.8	0.8
Kazakhstan	61.1	71	61.0	72.3	73.90	77.97	21	7.8
Russia	63.2	73.9	61.8	74.4	72.99	78.15	17	5.4
Compiled by authors by source [23]								

Thus, life expectancy for both men and women increased in all analyzed countries. At the same time, growth rates in developed countries differed insignificantly.

The performed analysis shows that the effectiveness of the functioning of the health care system and the degree of achievement of its goal of improving the health status of the population are associated not so much with the implementation of specific management methods, but with socio-economic conditions for their implementation and the existing system of medical care. This is confirmed by similar rates of increase in life expectancy at birth in developed countries, despite a significant difference in management tools, and actualizes a detailed study of the mechanism of the influence of socioeconomic conditions on the health of the population.

Acknowledgments: The article was prepared within the framework of the grant funding project of the Ministry of Education and Science of the Republic of Kazakhstan, "Development of national index of social wellbeing in regions of Kazakhstan and adaptation to conditions of global geopolitical, economic crisis" (IRN AP14869686).

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