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MAIN TRENDS IN THE DEVELOPMENT OF HEALTHCARE SYSTEMS

The article analyzes the main models of national health care systems in different countries of the world. It is emphasized that health care models are different approaches to the organization and financing of health care systems, which can be divided into three main categories: state (budgetary), where the state fully finances and manages the system, either according to the budget model (with some variations) or according to the Beveridge model; social insurance (often called «continental»), where financing is carried out through deductions from salaries and funds, and management is carried out through social insurance bodies; and market (private), where private clinics prevail and services are paid directly by patients or through private insurance.

The peculiarities of their formation and functioning are shown; the functioning of the model is determined by the principles of management, financing, organization of medical care and its accessibility to the population. The application of health care system models in China, Germany, France, Austria, Switzerland, the USA, Scandinavian countries, Great Britain, Ireland and others is considered. Fundamental differences between the systems are identified.

Disadvantages and advantages in the organization of medical care for the population are noted, taking into account the complex system of economic relationships of health care financing and the role of the state in management. The advantages of the state approach are universal

access and social protection, and the disadvantages are potential bureaucratization and inefficiency. The private model offers a high level of service and innovation, but suffers from accessibility for the poor and uneven quality. Insurance models combine public and private financing, striving for a balance between accessibility and efficiency, and mixed systems may have their own unique strengths and weaknesses.

Modern classifications of health care systems and a rating of the effectiveness of national health care systems are presented. It is emphasized that modern health care models differ in the structure of financing (budgetary, insurance, private), the organization of medical care (national, pluralistic) and the approach to health (biomedical, biopsychosocial). Their development is aimed at increasing the accessibility and quality of medical care, strengthening the primary care, introducing new technologies and efficient use of resources to preserve and improve the health of the population.

Keywords: *health care system, classification of health care systems, health care model, medical care, management.*

Statement of the problem in a general form. Today, there are a number of problems in the healthcare sector that are largely similar in most countries of the world. Demographic changes, the spread of chronic diseases, pandemics, rising healthcare costs – all these and other problems may arise much earlier than national economies and national healthcare models can effectively cope with them. It is also worth mentioning organizational problems, in particular, the vagueness or cumbersomeness of functioning healthcare systems. Non-communicable diseases, the number of which is growing as the population ages, impose a significant burden on the healthcare budget. The existing experience of most countries shows that significant socio-economic and political changes lead to an increase in a number of social problems that require corresponding changes in the healthcare sector. As a result, the need to choose the optimal healthcare model and system is a pressing problem for most national economies. In addition, the national model should demonstrate the resilience of the healthcare system to changes occurring, especially

in times of crisis. It is worth noting that by the end of the last century, many different problems had accumulated in the healthcare organization of most countries of the world, including the deterioration of health, the quality of medical care, etc. To a certain extent, these problems were due to the fact that countries finance their own healthcare services and organize medical care. Also, the trend of deterioration in health is quite logical, since the average life expectancy of the population is increasing all over the world. It is quite logical that this trend, on the one hand, leads to the spread of existing diseases of the elderly, and on the other hand, it produces the emergence and spread of completely different, new diseases. We can assume that further progress in the field of healthcare will allow people who are hopelessly ill to survive in the modern sense and will lead to a further increase in average life expectancy. However, this will require greater volumes of medical care and, as a result, an increase in the cost of providing it. That is why the governments of modern states are constantly analyzing their own models and health care systems, as well as searching for new approaches to organizing, financing and providing quality medical care in order to maintain and restore the health of their citizens. It is logical that the measures taken by modern states to ensure the optimal functioning of the health care sector are very diverse, since the current models and health care systems were not created immediately in their modern form. Also, these models and systems developed gradually and changed over a long period of time in accordance with national requirements and capabilities. Traditionally, it is customary to distinguish three main models of health care: state, insurance and private. In order to have a clearer idea of the advantages and disadvantages of a particular model and different health care systems, it is worth considering and analyzing health care systems operating in different parts of the world, comparing data on efficiency and compliance with the principles of social justice when providing medical care.

Results and Discussion. Today, each country in the world community creates and develops its own model of the health care system, which is characterized by the peculiarities of the distribution of economic resources for the provision of medical care and the preservation of the health of the population. The effectiveness of their application in the field of health

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care is determined by a number of features: a multifactorial system of political, economic, moral-ethical, cultural and other relationships that have historically developed in the country, etc. Despite the fact that the forms of organization of national health care systems are diverse, the goal of their activities is common – «improving the quality and accessibility of medical care, increasing life expectancy» [1].

Many classifications of health care systems are used in the world, which are explained by the essence of the classification adopted as the basis. As an example, based on the centralization of health care system management, centralized, decentralized and mixed models of health care system management are distinguished. At the same time, in countries where the state's influence on the formation of health care has historically been leading, there is a «gradual decentralization of some state functions and their redistribution to local authorities, which allows involving the population in determining priorities and reducing differences in the health status of the population, as well as introducing modern methods and technologies for managing this area» [18]. Currently, various concepts of state health care are not a strict copy of any of the models. They are so mixed that it is sometimes difficult to note which form is taken as a basis.

At one time, the WHO proposed a systematization, according to which three main modifications of the concepts of health care were distinguished: state, social insurance and market [11; 12]. The main feature of the state model is considered to be free medical care financed by the state, which prevails over the right of the state to provide medical services, as well as multi-level management of health care. The disadvantage of the state health care system is its low efficiency, as well as a significant share of financing from the budget, which leads to an increase in taxation. For example, the Soviet Semashko system was characterized by the centralization of state medicine, which made it possible to effectively cope with mass epidemics, contributed to an increase in average life expectancy due to the general accessibility and preventive focus of medical services, and mass anti-epidemic measures. However, the extensive construction of hospitals and excessive training of medical personnel led to irrational spending of funds. In the mid-1960s, the USSR spent about 6-6.5% of GDP on health care, and this

figure was high compared to Western countries. By the collapse of the USSR, this figure had decreased to 2-3% [7]. In addition, a doctor's salary depended on specialization, qualifications and academic degree, but not on performance. However, the Soviet model of health care was quite effective. As it developed, the USSR health care system became one of the few areas of state activity that received positive assessments from experts in capitalist countries. Many countries studied the experience of the Soviet model, and the WHO recommended using some of its elements (fig. 1) [9].

It is worth emphasizing that the long-term decline in the share of working-age citizens, the improvement of science, the introduction of new, expensive methods of diagnosis and treatment leads to an increase in healthcare costs. The increase in prices for medical services is a global trend, which leads to a limitation of the possibilities of financing the healthcare sector solely by the state. The state concept of healthcare is associated with a narrowing of the choice of a particular medical professional and medical institution, as well as territorial dependence and bureaucracy when receiving medical care.

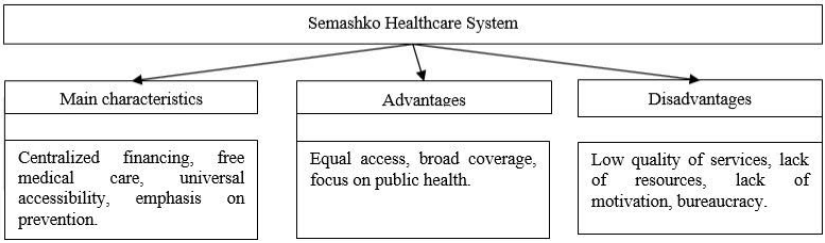

Fig. 1. Semashko healthcare system.
Source: formed by the author based on [9]

Quite close to the Semashko system is the Beveridge system, developed as part of the post-war social reconstruction program in Great Britain. This system was created as a social protection system in 1945 and included the provision of state guarantees for citizens and the use of social insurance for workers [8]. The state system led not only to an improvement in the quality of prevention, diagnosis and treatment of

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patients, but also to an increase in spending on the health care system (fig. 2).

Patients demands increased, unregulated supply and demand in unregulated conditions were formed, interrelated with the growth of patients' requirements for the frequency of visits and the volume of free medical care provided. This led to the need to implement stabilizing measures, similar to the introduction of certain amounts of payment, in the form of the patient paying a certain percentage for treatment. In addition, each patient was assigned to a general practitioner, which reduced the workload and ensured differentiated appointment of consultations by narrow specialists and a decrease in the level of hospitalization of patients [12]. One of the main bases of remuneration for medical workers was also introduced – funds were allocated per patient. This concept provided clients with the opportunity to freely choose a medical worker, and the total salary of a medical worker depended on the number of patients examined.

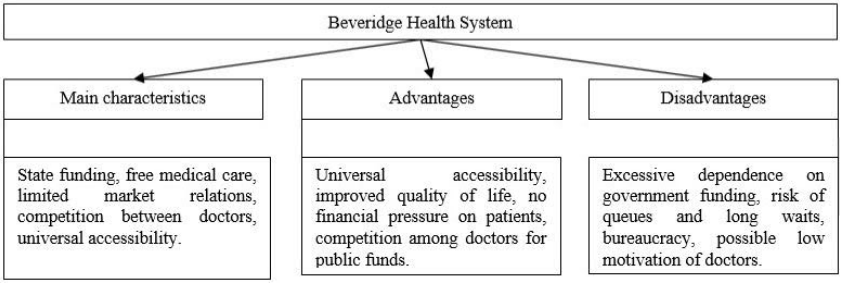

Fig. 2. Beveridge's health care system.
Source: formed by the author based on [12]

Subsequently, the category of general practitioners formed associations of fund holders who receive from the state an annual state budget containing resources for the therapy of doctors requiring inpatient treatment, the services of narrow-profile doctors, and even disease prevention. Similar organizations of medical professionals in England significantly reduced the costs of the health care system, while the quality of medical care was not affected [4]. Also, changes

to the «Beveridge» model of health care were widespread in Sweden, Denmark, Ireland, Italy and other countries. The basis was taken as state-controlled (budgetary) health care, improved by components of financing from other items, such as personal funds of patients and contributions from employers. The «Beverage» concept, as well as its changes, are characterized by significant significance for the state. Subsidization of health care is implemented mainly from the state budget and taxes. The state is considered the main consumer, as well as the supplier of medical services, guaranteeing universal accessibility and provision of the population with medical care.

In a number of Central and Eastern European countries, as well as in Germany, Belgium, the Netherlands, Austria, and Switzerland, the Bismarck model of health care is widespread. The historical goal of this system was to protect the health of workers as potential military personnel. The costs of medical care, unemployment benefits, and pensions were paid from the established social insurance funds. Later, «health insurance funds» were established [3]. About 60% of the contributions were provided by the employees themselves, and one third was provided by employers. Later, the «funds» turned into insurance companies, the basis of which were employer contributions. The rule of payment for medical services established by that time, developed as the basis for the development of the Bismarck concept, was replaced by a method of payment for services in points. The first method provoked the appointment of unnecessary and expensive operations, the second controlled healthcare costs, and the remuneration of medical workers depended on the results of treatment. This form remains the basis of healthcare in Germany and some other countries to this day [10].

The Bismarck system and its modifications, based on the principles of public insurance, as well as market regulation with a multi-channel financing concept, are positioned as a social insurance or regulated health insurance concept. This form of health care is based on the principles of a mixed economy, combining the medical services market together with the established concept of state regulation, as well as social support and accessibility of medical care for absolutely all categories of citizens (fig. 3). The state represents a significant structure in supporting socially

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necessary needs and medical care of the majority of people regardless of income level and without violating the foundations of the market for payment for medical services [3].

The role of consumers of medical services is performed by insurance companies. The importance of the medical services market lies in meeting people's needs beyond those guaranteed by the state, supporting independence of choice. A multi-factor financing system (due to targeted contributions of entrepreneurs, employees, the government budget, the concept of compulsory medical insurance) creates the necessary plasticity, as well as the stability of the financial basis of social insurance medicine. This model has manifested itself most clearly in Germany, France, the Netherlands, Austria, Belgium, Switzerland, Canada, and Japan [12].

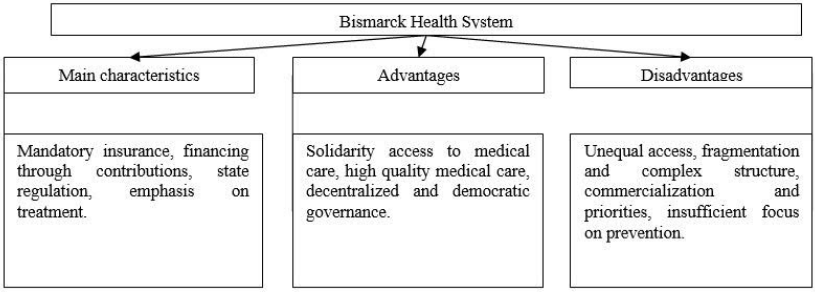

Fig. 3. Bismarck's health care system.
Source: formed by the author based on [3]

There is no general state concept of health insurance in the USA. The US Constitution guarantees state support for providing medical care only to needy categories of citizens. The structure of financing the healthcare sector in the USA consists of the following sources: personal expenses of citizens due to health insurance and funds regulated by the state and those that go to healthcare programs, mandatory deductions of enterprises for the «MediCare» and «MedicAid» programs [21]. The advantages of this system are considered to be a wide range of medical services, guaranteed specialized care, an individual approach to the

patient, comfortable conditions during hospitalization. According to professionals, the US healthcare concept is characterized by relatively low efficiency, as well as rapid growth in costs [24]. The increase in the cost of voluntary health insurance policies (insurance deduction structure: 70% – employer, 30% – employee) reduces the availability of medical care for some segments of the population.

In Canada, health insurance is represented by a system of health insurance savings accounts, based on employer contributions and owned by the employee. The funds accumulated by the employee in the employer's account contribute to a 20% reduction in medical care costs. This system guarantees the employee confidence in the accumulation of funds and the ability to use them if necessary, while rationalizing the approach to the choice of medical services (67%) and increasing the responsibility of medical personnel (55%) [15]. If the funds in the savings account are insufficient, the state can subsidize additional insurance premiums. This insurance model is economically advantageous, since it is based on the interaction and interest of the patient and the specialist.

In Japan, insurance has a territorial feature and is nationwide in nature, including owners and members of their families, the disabled and the unemployed. 70-90% of the cost of medical services provided to these categories of citizens is paid by the state. Consulting physicians, social security authorities, and the Ministry of Health strictly control healthcare pricing [23].

Thus, health care models, taking into account the source of subsidy, are divided as follows:

– general taxation (Scandinavian countries, Ireland, Great Britain, Greece, Spain, Italy, Portugal, etc.). In these countries, the leading role is assigned to the public sector as the main source of financing, which ensures the availability of medical services to the population [18];

– social insurance (Austria, Belgium, Germany, Luxembourg, France, Switzerland). The state exercises control both from the standpoint of reducing costs and from the side of guaranteeing general equality and solidarity;

– social insurance at the expense of a single social tax (most countries of Central and Eastern Europe, the CIS) [17].

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The state health care sector cannot constantly guarantee a high level of medical care due to lack of funding, as well as inefficient distribution of available funds. Private medical care is not available to everyone. Therefore, the concept based on health insurance is recognized as an appropriate form of organizing care. As the best option, insurance medicine should guarantee high-quality medical care at the expense of its own funds to every insured citizen. In this way, a accumulative insurance option can be implemented when the funds are not needed by the patient. But periodically the patient does not have the opportunity to choose a medical institution, a doctor and the cost of the service, especially in emergency situations. Under such conditions, an insurance asset (fund) can help as a stabilizer of the relationship between a medical professional and a patient. Another significant feature in the relationship between an insurance company and an insured person is employers. In addition to the fact that they need strong, productive employees, employers, together with a package of social services, attract employees with significant insurance contributions that are not taxed [17].

The study of currently available health care concepts, based on the categories of states classified at different levels of social development, involves emphasizing the following modifications: universalist, continental, southern, Scandinavian, market, models in countries with economies in transition [5]. The indicated models differ significantly in such indicators as:

– the role and place of the state in the processes of financing the health care sector;
– types of ownership of medical service producers;
– coverage of citizens by state aid programs;
– options for financing health care;
– types of health care management [5].

1. The universal model (Ireland, England) is represented by a state concept of health care, which is financed in a significant amount in the form of a single tax, that is, it is based on the state budget option (fig. 4). Medical services are provided mostly in state medical organizations (primary health care, pharmacists, dentists). Dominance of primary health care. High percentage of general practitioners who provide medical care to the majority of the population.

The positive aspects of this model include the following positions:

– the predominance of the state form of financing healthcare;

– state redistribution of local budgets of healthcare organizations by directing financial resources from regions with a higher quality of life to regions with a lower one;

– relatively low (compared to other states) healthcare expenditures guarantee higher indicators of the population's health status;

– a differentiated concept of remuneration for the work of general practitioners, related to the number and structure of residents served in the territory [16].

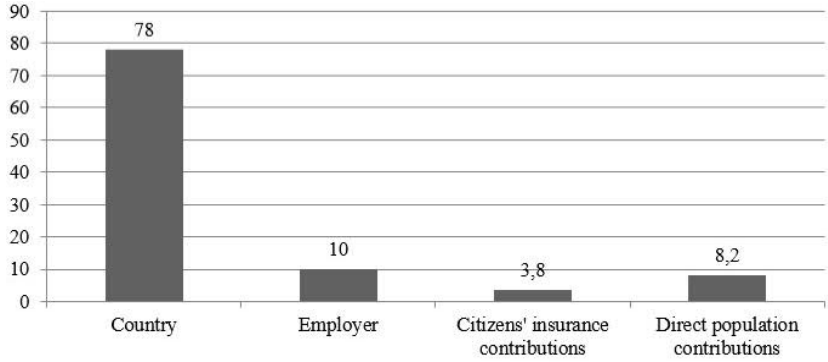

Fig. 4. Financing options in the UK universal healthcare model.
Source: formed by the author based on [16]

Today, the universal healthcare model is developing by expanding access to medical services, improving the quality and accessibility of medical care through digitalization, as well as the use of comprehensive approaches to health that take into account not only biological, but also psychosocial and existential factors (fig. 5).

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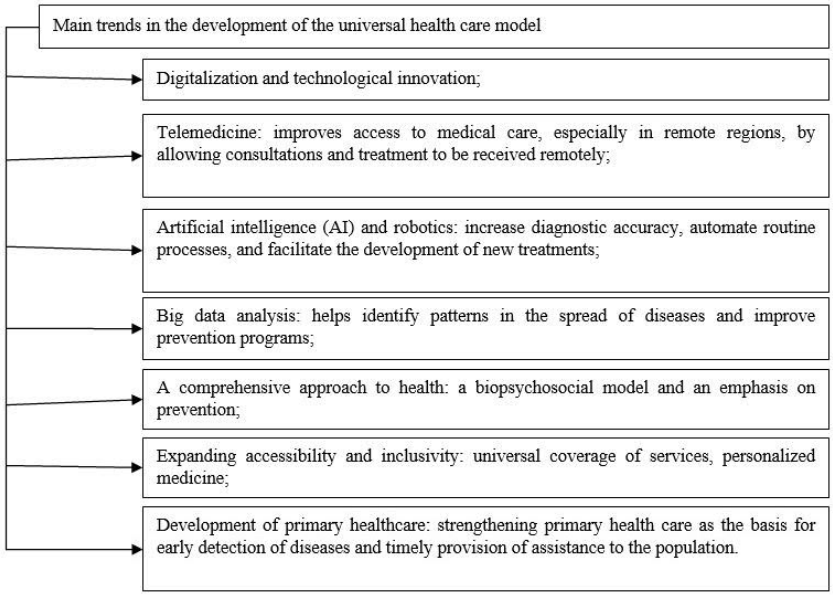

Fig. 5. Main trends in the development of the universal health care model.
Source: formed by the author

In general, the universal healthcare model seeks to create a flexible, accessible and customer-oriented system that can effectively respond to the challenges of modernity and ensure a high quality of life for all citizens.

2. The continental model (Austria, France, Germany, the Netherlands, Belgium) is based on subsidies, which are implemented through deductions from the payroll fund, as well as from specialized municipal funds. It is based on a social insurance form (fig. 6) [13].

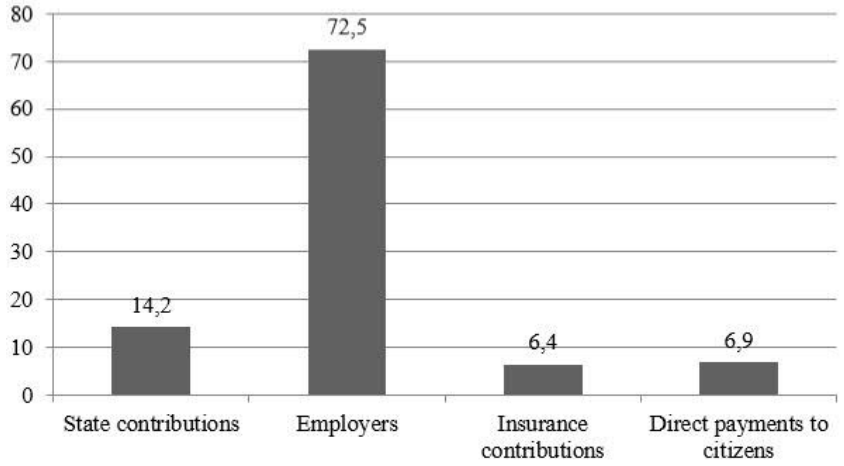

Fig. 6. Financing options in the continental healthcare model of Germany. *Source: formed by the author based on [13]*

In total, individual funds of citizens in the financing scheme account for 13.3%. In Germany, about 1,200 insurance organizations cover 88% of the population with their assistance. Essentially, these funds are financed from the funds of workers, as well as employers, according to the principle of coordinated payment of health insurance. All citizens have the opportunity to purchase health insurance, while the insurance premium cannot be overstated due to the patient's illness. Insurance contributions of people of retirement age are dated by pension insurance and the pensioners themselves.

Unemployment insurance is implemented by the Federal Employment Agency. Any insured person and their entire family have the right to choose a doctor and receive the necessary medical care, including outpatient and inpatient treatment. The disadvantage of this system is the financing of a large state apparatus for implementing interaction with medical organizations [12]. Today, this model directs the main efforts to implement the main areas of further development, including strengthening the role of the state and insurance funds, integrating private and public assistance, introducing digital technologies, and focusing on prevention and primary health care (fig. 7) [12].

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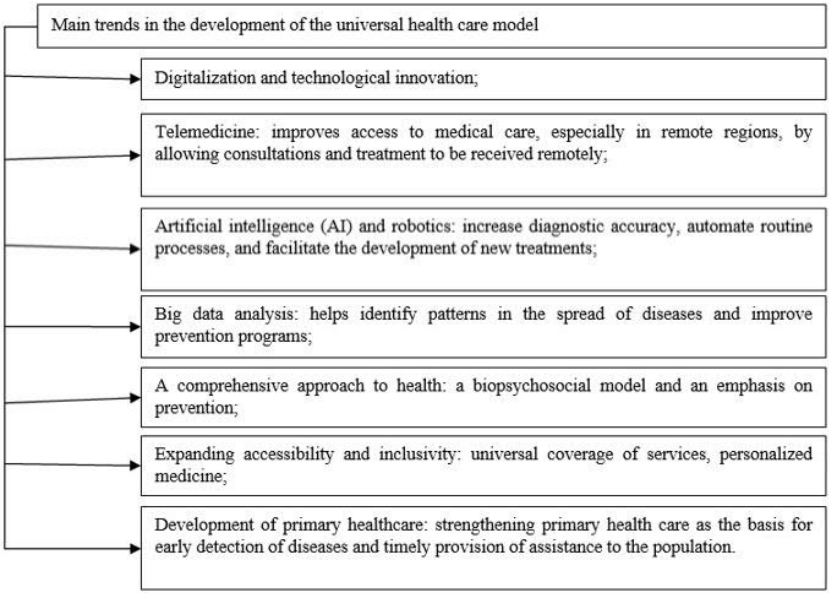

Fig. 7. Promising directions of development of the continental mode.
Source: formed by the author based on [12]

3. The Scandinavian model (Denmark, Sweden, Finland) is a health care system characterized by a fairly wide coverage of all citizens, financing mainly through relevant taxes, rather than insurance contributions, and guaranteed access to social services and payments as a legal right of every person. This model is based on the principles of social solidarity and high organization of society. And the amount of assistance directly depends on the size of the salary. Medical care is provided equally by both municipal and private clinics. General accessibility, as well as a high level of medical service, the formation of equivalent conditions for maintaining health are implemented through effective state regulation and financing of health care (fig. 8) [22].

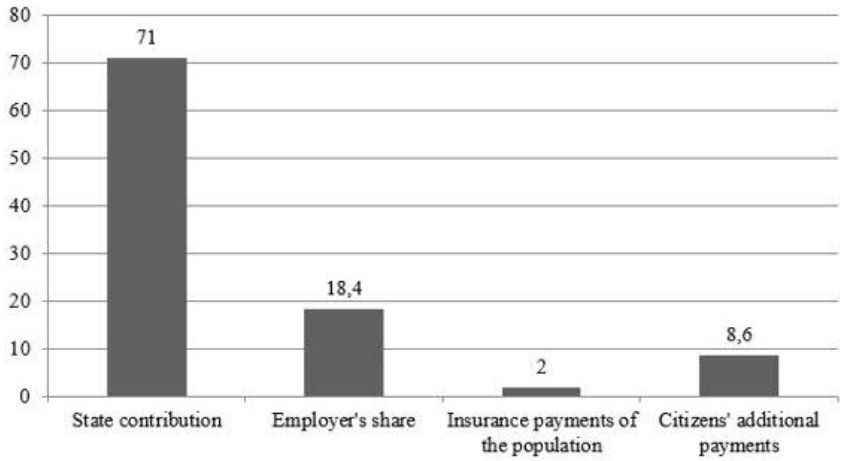

Fig. 8. Components of financing of the Scandinavian model (using the example of Sweden).
Source: formed by the author based on [22]

The Scandinavian model of healthcare has certain characteristics. Local councils are primarily responsible for the provision of healthcare services to residents in a given area. The councils represent the owners of healthcare facilities and provide employment for many healthcare workers. A significant share of healthcare costs is borne by the state, but about 10% of services are paid for by the population. When purchasing medicines prescribed by a doctor, health insurance reimburses the patient from 50 to 100% of the costs [19].

In terms of development trends, the Scandinavian healthcare model focuses on preserving the core strengths of universal access and high-quality services, which are largely financed by taxes. However, the challenge of ensuring sustainable financing in the face of an aging population and rising costs remains [20]. Development includes the introduction of digital technologies to increase efficiency, strengthening prevention and personalized medicine, and finding a balance between the public and private sectors to meet the needs of the population.

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Therefore, the Scandinavian model, despite its challenges, has good prospects due to its flexibility, human-centeredness, and ability to integrate new technologies to adapt to change.

4. The market model (USA, Israel) is aimed at providing medical services as a commodity sold on a free market with minimal state intervention. And the financing of such a system is carried out at the expense of private funds and commercial insurance. For example, the health care system in the USA is based on the laws of the free market, in which professional medical organizations have great influence. The most common example is «Health Maintenance Organizations», which are insurance companies that exist within the framework of strong competition and work according to various schemes [13]. The system underlying the work of this organization is «managed medical care» [14]. Health maintenance organizations have excellent management systems that allow significantly reducing the cost of medical services. In addition to the USA, this model is used in the health care systems of Israel and South Korea.

In the USA, two types of private health insurance are used: individual and group. In the case of the group option, the employer and all employees of the company are included in a single insurance policy. There are programs «MediCare» and «MedicAid», which receive funding from the federal budget, state budgets, local governments (fig. 9) [12].

Regarding the above programs, the state program «MediCare» consists of two parts: the first provides for mandatory medical insurance for people aged 65 and over during hospitalization, the second provides for voluntary insurance, with the state paying 80% of the amount for treatment, and patients paying 20%. Another state program «MedicAid» is aimed at supporting the provision of free medical care to disabled people and families with children. Within the framework of this program, the redistribution of the allocated state budget is opposite to the level of income per person in a given state [12].

The US health care model is characterized by a number of features, including the rapid growth of health care financing, which cannot be compared with the growth rate and quality of medical services. The disadvantages of this model include:

– the cost of medical services includes a high percentage of costs for administrative procedures (sometimes up to 20%);

– the salary of medical workers directly depends on the number and cost of prescribed procedures and prescribed medications;

– prices for the same services in different states have a large range (difference of up to 10-15 times);

– a complex concept of health insurance [12].

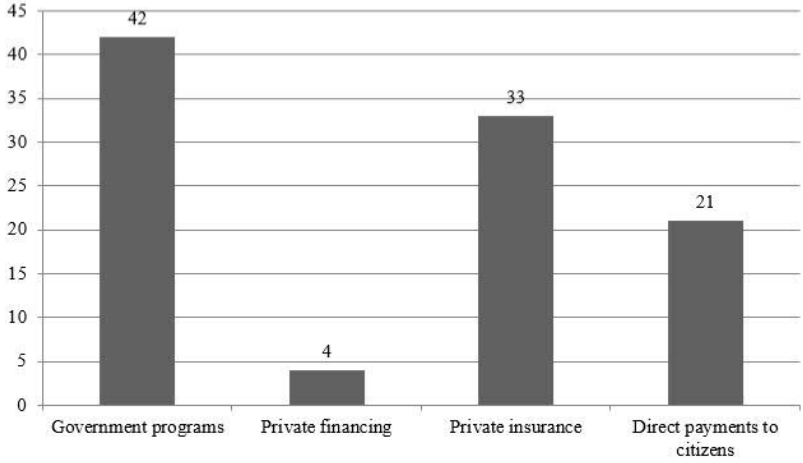

Fig. 9. Components of financing a market model of healthcare (on the US device).

Source: formed by the author based on [12]

It is worth noting that the specified model, despite certain shortcomings, is aimed at further development with prioritization of certain issues regarding:

– increasing quality and innovation through increased competition;

– overcoming difficulties in accessing medical care for low-income groups of the population;

– reducing the cost of certain medical services;

– increasing the impact on the market economy, etc.

So, taking into account the above, we can say that modern healthcare models are trying to constantly improve and meet the requirements of the

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time. The presence of a large number of different concepts and reforms in the healthcare sector indicates that none of the existing models is perfect. Any modern state is trying to form a more effective version of its own model, focusing on the positions of ideology, economics, and healthcare mentality, therefore, simply borrowing ideas and duplicating effective concepts does not necessarily lead to a positive result. Indicative in this regard may be the experience of China, which effectively combines the achievements of Western medicine with traditional Chinese medicine, focusing on comprehensive care and disease prevention. In addition, China is actively developing the infrastructure of medical institutions, introducing digital technologies and reforming the insurance medicine system. These actions are aimed at maximizing coverage and providing high-quality care to the entire population, including:

– the development of insurance medicine (further expansion of insurance coverage to make medicine more accessible to the general public);

– digitalization and technology (the introduction of modern technologies, including electronic medical records and telemedicine, to increase the efficiency and accessibility of medical services);

– an emphasis on prevention (strengthening the prevention of various diseases and strengthening public health, preventing relapses and deterioration of well-being in the future) [6].

In addition, the main directions of further development in the field of health care in China are clearly outlined, namely:

– reducing morbidity and mortality by improving population health indicators;

– improving the accessibility of medical care for the entire population of the country;

– further reducing healthcare costs through the integration of traditional Chinese medicine, preventive measures and digitalization, etc. [2].

It is worth emphasizing that China's healthcare system seems complex, but it is very dynamic, constantly adapting to the current needs of its citizens, trying to effectively balance between traditional and modern approaches to medicine.

Conclusion. Thus, the analysis of modern health care models and systems shows that there are no «pure» models and health care systems, just as there are no «ideal» ones. Any health care model or system to a greater or lesser extent generates organizational, structural and financial problems, and as a result, social inequalities in the field of public health. Increasing health care spending will not improve public health and will not completely eliminate existing problems, but may become a risk to the sustainable development of the system itself, especially in times of economic crisis. That is, a unified comprehensive concept is needed, regardless of the model and health care system, which would allow identifying the existing needs of the population and developing the most effective ways to meet them. This requires methods and mechanisms that direct financial resources to specific goals of the health care system, as well as timely identifying the most disadvantaged areas in the field of preserving public health.

ОСНОВНІ ТЕНДЕНЦІЇ РОЗВИТКУ СИСТЕМ ОХОРОНИ ЗДОРОВ'Я

В статті проаналізовано основні моделі національних систем охорони здоров'я різних країн світу. Наголошено, що моделі охорони здоров'я – це різні підходи до організації та фінансування систем охорони здоров›я, які можна розділити на три основні категорії: державна (бюджетна), де держава повністю фінансує та керує системою, як за бюджетною моделлю (з окремими варіаціями) чи за моделлю Беверіджа; соціально-страхова (часто звана «континентальною»), де фінансування здійснюється через відрахування із зарплат та фондів, а управління – через органи соціального страхування; та ринкова (приватна), де переважають приватні клініки та послуги оплачуються безпосередньо пацієнтами або через приватні страховки.

Показано особливості їх формування та функціонування; функціонування моделі визначається принципами управління, фінансування, організації медичної допомоги та її доступності населенню. Розглядається застосування моделей систем охорони

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здоров'я у Китаї, Німеччині, Франції, Австрії, Швейцарії, США, країнах Скандинавії, Великобританії, Ірландії та інших. Виявлено принципові відмінності між системами.

Відзначено недоліки та переваги в організації медичної допомоги населенню з урахуванням складної системи економічних взаємовідносин фінансування охорони здоров›я та ролі держави в управлінні. Перевагами державного підходу – є загальний доступ та соціальний захист, а недоліками – потенційна бюрократизація та неефективність. Приватна модель пропонує високий рівень сервісу та інновацій, але страждає від доступності для малозабезпечених та нерівної якості. Страхові моделі поєднують державне та приватне фінансування, прагнучи балансу між доступністю та ефективністю, а змішані системи можуть мати свої унікальні сильні та слабкі сторони.

Наведено сучасні класифікації систем охорони здоров›я та рейтинг ефективності національних систем охорони здоров'я. Наголошено, що сучасні моделі охорони здоров'я розрізняються по структурі фінансування (бюджетна, страхова, приватна), організації медичної допомоги (національна, плюралістична) та підходу до здоров'я (біомедична, біопсихосоціальна). Їх розвиток спрямований на підвищення доступності та якості медичної допомоги, зміцнення первинної ланки, впровадження нових технологій та ефективне використання ресурсів для збереження та зміцнення здоров'я населення.

Ключові слова: *система охорони здоров'я, класифікація систем охорони здоров'я, модель охорони здоров'я, медична допомога, управління.*

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References

1. Artsatbanova, O.V. (2017). Porivnialnyi analiz pidkhodiv do pobudovy ekonomichnykh mekhanizmiv funktsionuvannia systemy okhorony zdorovia [Comparative analysis of approaches to building economic mechanisms for the functioning of the health care system]. *Derzhavne upravlinnia: udoskonalennia ta rozvytok – State administration: improvement and development*, 10. Retrieved from: http://www.dy.nayka.com.ua/?op=1&z=1399 [in Ukrainian].

2. Initsiatyva «Zdorovyi Kytai 2030» [Healthy China 2030 Initiative]. (n.d.). (2016). *www.gov.cn.* Retrieved from: http://www.gov.cn/gongbao/content/2016/content_5133024.htm [in Ukrainian].

3. Dolot, V.D., Dutka, V.V., & Liakhovchenko, L.A. (2012). Likarniani kasy yak dodatkove dzherelo finansuvannia systemy okhorony zdorovia Ukrainy (na prykladi blahodiinoi orhanizatsii «Munitsypalna likarniana kasa mista Kyieva») [Health insurance funds as an additional source of financing the health care system of Ukraine (on the example of the charitable organization «Municipal Health Insurance Fund of the City of Kyiv»)]. *Investytsii: praktyka ta dosvid – Investments: practice and experience*, 5. Retrieved from: http://nbuv.gov.ua/UJRN/ipd_2012_5_29 [in Ukrainian].

4. Frantsuzka i brytanska modeli okhorony zdorovia (ohliad) [French and British models of health care (review)]. (n.d.). (2020). *msvitu.com.* Retrieved from: http://msvitu.com/archive/2014/may/article-9.php [in Ukrainian]

5. Kalinichenko, S.M., Avriata, A.V., Kharchevnikova, L.S., & Oliinyk, I.A. (2023) Zakordonnyi dosvid: modeli finansuvannia ta orhanizatsii system okhorony zdorovia [Foreign experience: models of financing and organization of health care systems]. *Aktualni problemy innovatsiinoi ekonomiky ta prava – Current problems of innovative economics and law*, 5-6, (pp. 53-58) [in Ukrainian].

6. Kurnosenko, L.V. (2022). Mekhanizm reformuvannia systemy okhorony zdorovia Kytaiskoi Narodnoi Respubliky [Mechanism of reforming the health care system of the People's Republic of China]. *Efektyvnist derzhavnoho upravlinnia – Effectiveness of public administration*, 1-2. Retrieved from: http://nbuv.gov.ua/UJRN/efdu_2022_1-2_7 [in Ukrainian].

7. Lekhan, V.M., Slabkyi, H.O., & Shevchenko, M.V. (2009). *Stratehiia rozvytku okhorony zdorovia: ukrainskyi vymir [Strategy for the development of health care: Ukrainian dimension]*. Kyiv: Tsyfra [in Ukrainian].

8. Lekhan, V.M., & Rudyi, V.M. (2005). *Osnovni shliakhy podalshoho rozvytku systemy okhorony zdorovia v Ukraini. Spilnyi zvit [Main ways of further development of the health care system in Ukraine. Joint report]*. Kyiv: Vyd-vo Raievskoho [in Ukrainian].

9. Lekhan, V., Hinzburh, V., & Borvinko, E. (2013). Porivnialna kharakterystyka modeli Semashka ta modeli, zapochatkovanoi v ramkakh reformy systemy okhorony zdorovia v Ukraini [Comparative characteristics of the Semashko model and the model initiated within the framework of the health care system reform in Ukraine]. *Medytsyna sohodni i zavtra – Medicine today and tomorrow,* 61(4). Retrieved from: https://msz.knmu.edu.ua/article/view/99 [in Ukrainian].

10. Lytovchenko, I. (2022). Suchasnyi stan rozvytku systemy okhorony zdorovia federatyvnoi respubliky Nimechchyna [Current state of development of the health care system of the Federal Republic of Germany]. *Naukovi pratsi Mizhrehionalnoi Akademii upravlinnia personalom. Politychni nauky ta publichne upravlinnia – Scientific papers of the International Academy of Personnel Management. Political Science and Public Administration,* 2(62). Retrieved from: https://journals.maup.com.ua/index.php/political/article/view [in Ukrainian].

11. Malikina, O., Andriiash, V., Kozlova, L., & Poliakova, O. (2020). Osoblyvosti derzhavnoi polityky rehuliuvannia medychnykh posluh v Ukraini [Peculiarities of the state policy of regulating medical services in Ukraine]. *Publichne upravlinnia ta rehionalnyi rozvytok – Public administration and regional development,* 9. Retrieved from: https://dspace.chmnu.edu.ua/jspui/bitstream/.pdf [in Ukrainian].

12. Malikina, O., Andriiash, V., & Poliakova, O. (2019). Mizhnarodnyi dosvid finansuvannia reform u sferi okhorony zdorovia [International experience in financing reforms in the health sector]. *Publichne upravlinnia ta rehionalnyi rozvytok – Public administration and regional development,* 5. Retrieved from: https://dspace.chmnu.edu.ua/jspui/handle/123456789/1523 [in Ukrainian].

13. Melnyk, A. (2022). Transformatsiina model rynku okhorony zdorovia v Ukraini v umovakh suchasnykh vyklykiv [Transformational model of the healthcare market in Ukraine in the face of modern challenges]. *Visnyk ekonomiky – Bulletin of Economy,* 2. Retrieved from: http://nbuv.gov.ua/UJRN/Vtneu_2022_2_11 [in Ukrainian].

14. Reshota, N. (2020). Klasyfikatsiia osnovnykh modelei medychnykh system u sviti ta shliakh Ukrainy [Classification of the main models of medical systems in the world and the path of Ukraine]. *ingeniusua.org.* Retrieved from:

https://ingeniusua.org/articles/klasyfikatsiya-osnovnykh-modeleymedychnykh-system-u-sviti-ta-shlyakh-ukrayiny [in Ukrainian].

15. Savytskyi, V.L., Klishevych, B.A., & Honcharenko, I.F. (2016) Orhanizatsiia derzhavnoi (tsyvilnoi) okhorony zdorovia ta osvity v Kanadi [Organization of state (civilian) health care and education in Canada]. *Visnyk sotsialnoi hihiieny ta orhanizatsii okhorony zdorovia Ukrainy – Bulletin of social hygiene and health care organizations of Ukraine,* 4. Retrieved from: http://nbuv.gov.ua/UJRN/VSG_2016_4_13 [in Ukrainian].

16. Seniuk, Yu.I., & Nadiuk, Z.O. (2020). Suchasna derzhavna polityka u sferi okhorony zdorovia: analiz reformuvannia systemy [Modern state policy in the field of health care: analysis of system reform]. *Pravo ta derzhavne upravlinnia – Law and state administration,* 2. Retrieved from: http://pdu-journal.kpu.zp.ua/archive/2_2020/34.pdf [in Ukrainian].

17. Shandar, A.M., & Kyryliuk, V.V. (2023). *Medychne strakhuvannia v systemi sotsialnoho zabezpechennia Ukrainy [Medical insurance in the social security system of Ukraine]*. Ternopil: TNTU. Retrieved from: https://galicianvisnyk.tntu.edu.ua/pdf/85/1245.pdf [in Ukrainian].

18. Sheliemina, N.I. (2023). Osoblyvosti finansuvannia systemy okhorony zdorovia: vitchyznianyi ta zakordonnyi dosvid [Peculiarities of financing the health care system: domestic and foreign experience]. *Ekonomika ta suspilstvo – Economy and society,* 53. Retrieved from: https://economyandsociety.in.ua/index.php/journal/article/view/2691 [in Ukrainian].

19. Skandynavska model: sekret uspikhu krain Pivnichnoi Yevropy chy systema, pozbavlena maibutnoho? [Scandinavian model: the secret of success of the countries of Northern Europe or a system devoid of the future?]. (n.d.). (2020). *adastra.org.ua*. Retrieved from: https://adastra.org.ua/blog/skandinavska-model-sekret-uspihu-krayin-pivnichnoyi-yevropi-chi-sistema-pozbavlena-majbutnogo [in Ukrainian].

20. Smirnova, V.L., Klymuk, N.Ia., & Vakulenko, D.V. (2020). Analiz modelei medychnoho strakhuvannia [Analysis of health insurance models]. *Visnyk sotsialnoi hihiieny ta orhanizatsii okhorony zdorovia Ukrainy – Bulletin of social hygiene and health care organizations of Ukraine,* 3. Retrieved from: http://nbuv.gov.ua/UJRN/VSG_2020_3_19 [in Ukrainian].

21. Stepanova, O.V., & Iholkin, I.V. (2012). Reformuvannia systemy okhorony zdorovia u SShA [Reforming the health care system in the USA]. *Finansy Ukrainy – Finance of Ukraine,* 3. Retrieved from: http://nbuv.gov.ua/UJRN/Fu_2012_3_7 [in Ukrainian].

22. Sukhovyi, H.P., & Yakovleva, O.S. (2020). Osoblyvosti funktsionuvannia modelei finansuvannia medychnoho strakhuvannia [Peculiarities of functioning

 DOI 10.34132/pard2025.29.06

of models of financing of medical insurance]. *Proceedings from MSIP '20: I Mizhnarodna naukovo-praktychna konferentsiia «Suchasna nauka: innovatsii ta perspektyvy» – I International Scientific and Practical Conference «Modern science: innovations and prospects»*. Stockholm, Sweden. Retrieved from: https://dspace.zsmu.edu.ua/bitstream/123456789/14892/1/%D1%8179-85.pdf [in Ukrainian].

23. Systema okhorony zdorovia v Yaponii [Health care system in Japan]. (n.d.). (2023). Retrieved from: http://msvitu.com/archive/2013/november/article-10.php [in Ukrainian].

24. Davis, K., Schoen, C., & Stremikis, K. (2010). How the Performance of the U.S. Health Care System Compares Internationally. *www.commonwealthfund.org.* Retrieved from: http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update [in English].

25. Global Health Observatory data repository. (n.d.). (2020). *apps.who.int*. Retrieved from: http://apps.who.int/gho/data/?theme=home [in English].

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