Д. Баюра, д-р екон. наук, проф.
Київський національний університет імені Тараса Шевченка, Київ, Україна,
В. Головій, асп.
Київський національний університет імені Тараса Шевченка, Київ, Україна,
Університет Норд, Норвегія

ІНТЕРПРЕТАТИВНЕ ЧИТАННЯ РИНКОВОГО ДОСЛІДЖЕННЯ: КЕЙС ІЗ КОНСАЛТИНГОВОЇ ПРАКТИКИ

З метою отримання нового знання, що впливає на ухвалення важливих бізнесових рішень й у такий спосіб опосередковано перетворює дані у відповідні дії, можна використовувати найрізноманітніші методи та види даних – залежно від таких факторів, як їхня наявність, доступність і вартість. У консалтингу звернення до опублікованих та широкодоступних ринкових звітів і досліджень стало рутинною практикою. Пропонована стаття – приклад того, як можна на практиці застосовувати інституціональну теорію у процесі читання, аналізування й інтерпретування даних із типового ринкового дослідження. Нині, на відміну від широковживаних теорій та числових і якісних методів, застосування інституціональної теорії є для галузевих практиків і консультантів зі стратегії радше винятком, ніж правилом. У наведеному кейсі з виноробної галузі маркетингове дослідження було герменевтично "прочитане" через призму інституціональної теорії, що допомогло виявити два види ізоморфізму на ринках Грузії та України.

Ключові слова: інституційна теорія, ізоморфізм, винна індустрія, стратегія, герменевтика, інтерпретативне читання.

Д. Баюра, д-р экон. наук, проф.
Киевский национальный университет имени Тараса Шевченко, Киев, Украина,
В. Головий, асп.
Киевский национальный университет имени Тараса Шевченко, Киев, Украина,
Университет Норд, Норвегия

ИНТЕРПРЕТАТИВНОЕ ПРОЧТЕНИЕ РЫНОЧНОГО ИССЛЕДОВАНИЯ: КЕЙС ИЗ КОНСАЛТИНГОВОЙ ПРАКТИКИ

Для получения новых знаний, которые влияют на принятие ответственных решений в бизнесе и, таким образом, опосредовано превращаются в действия, используется множество теоретических подходов, исследовательских методов и видов данных – в зависимости от наличия, доступности и стоимости последних. В консалтинговой практике обращение к данным, опубликованным в рыночных отчетах и маркетинговых исследованиях, является стандартной практикой. Предлагаемая статья – пример применения отраслевыми практиками и консультантами по стратегии на практике институциональной теории к анализу и интерпретации данных, содержащихся в типовом рыночном исследовании, что, в отличие от широко распространённых теорий, количественных и качественных методов, представляется скорее исключением, чем правилом. Этот кейс из винной индустрии – герменевтическое прочтение маркетингового исследования через призму институциональной теории, что способствовало идентификации двух типов изоморфизма на рынках Грузии и Украины.

Ключевые слова: институциональная теория, изоморфизм, винная индустрия, стратегия, герменевтика, интерпретативное прочтение.

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N. Hrazhevska, Dr Hab., Prof.
ORCID ID 0000-0003-2549-8055
Taras Shevchenko National University of Kyiv, Kyiv, Ukraine,
A. Tyngisheva, Doctor PhD
ORCID ID 0000-0002-1957-4325
Karaganda university of Kazpotrebsoyuz, Republic of Kazakhstan

PUBLIC ADMINISTRATION MODELS AND HEALTHCARE SYSTEM REGULATION IN FOREIGN COUNTRIES

The article focuses on a comparative analysis of public administration models and healthcare system regulation in foreign countries. The study explores organizational features of the operation and development of healthcare systems and identifies three types of healthcare financing: budgetary, insurance, and private sources. Particular attention is paid to the current state of healthcare systems and their readiness to prevent coronavirus pandemics.

Keywords: healthcare system, public administration, healthcare financing, coronavirus pandemic.

Problem statement. One of the most important and socially significant areas of state policy that requires from the government a balanced approach is the public administration system in the healthcare sector, which has a direct impact on the welfare, life, and health of the population.

The fundamental factor determining the effective and sustainable healthcare operation is the industry financing, characterized by volumes, model, and implementation mechanisms. The problems associated with financing healthcare are most urgent because the modern world healthcare is considered to be one of the fundamental human rights with health development, as a specific type of economic activity that cannot be limited to any country. This is since the level of development of healthcare in a particular country affects the entire world. For a long time, most of the countries of the European Union were among the leaders in the ranking of the effectiveness of the healthcare system. However, despite a fairly high level of development of healthcare in the analyzed countries, the healthcare systems of European countries were not sufficiently prepared to ward off the pandemic.

Analysis of recent research and publications. The functioning of the public sector with the health sector as its important component and problems of their development are disclosed in numerous works of many distinguished foreign scientists. An in-depth study of financing and government regulation of medical services, the mismatch of medical services markets with competitive markets, the introduction of health insurance, and the implementation of reforms in the health sector is presented in the well-known book by J. Stiglitz "Economics of the Public Sector" [1]. The specific properties of medical care as an object of the normative economy, the comparative characteristics of the medical service industry with the norms of the welfare economy, the analysis of the inefficiency of the medical

services market due to the asymmetry of information, the uncertainty of demand, external effects in the health sector were reflected in the studies of K. Arrow [2, p. 941–973]. T. Goetzen revealed in detail the main problems of production and economic analysis of health services; described the means for stimulating and developing the organizational structure of the healthcare system based on the analysis of the corresponding financial flows; identified the determinants of changes in government spending on healthcare, and also analyzed the impact of government on public and private healthcare [3]. A fundamental study of the economic crisis consequences and implications for the European healthcare system reforming was published in 2015 by experts from the WHO Regional Office for Europe in conjunction with the European Observatory on Health Systems and Policies [4]. The problems of the specifics of competition in the healthcare sector, the degree of its influence on the quality of healthcare, public welfare, and consumer choice were considered by T. Rice [5], D. Dranov and M. Satterthwaite [6], A. Enthoven [7], M. Porter and E. Teisberg [8] et al.

The aim of the article is a comparative analysis of the public administration models and regulation of healthcare systems of foreign countries, identification of the features, as well as the possibilities of using their successful experience in Ukraine and Kazakhstan.

Methodology. The article starts with a review of modern literature focused on the models of the healthcare systems with an account for their organizational and financial characteristics. A comparative analysis of the practice of public administration and regulation of the healthcare systems in foreign countries yields its logical generalization. A systematic approach and comparative analysis were used at all stages of the study to compare current health financing and organizational management systems. Some statistical techniques and methods were used to process the collected data.

Main results. From the point of view of organizational and financial characteristics, the following healthcare systems are distinguished: predominantly state, predominantly social insurance, predominantly private.

The predominantly state healthcare system is characterized by a significant role of the state (UK, Greece, Denmark, Ireland, Spain, Italy, Norway, Portugal, Sweden, etc.). The basic example of this system is N. Semashko's system, created in the Soviet Union. It was modified and used in the UK from 1944. Funding is provided mainly from the public resources pooled by tax revenues to the state budget. This model is traditionally based on the system of public medical institutions.

The predominantly social insurance healthcare system (Austria, Belgium, the Netherlands, Germany, France, Switzerland, Japan, some Latin American countries) assumes that funding is carried out on a tripartite basis: from budget allocations, contributions from employers, and contributions from employees themselves, which implies the availability of compulsory health insurance.

The predominantly private (the USA, South Korea, etc., Azerbaijan, and Georgia began to approach this group) healthcare system is mainly based on private medical practice with payment for medical services at the expense of the patient. In almost no country in the world, these systems do not function in their pure form, since they are not only constantly being modified, but each country, based on the economic situation, determines which system to give preference to in a certain period of state development [9, p. 23–27].

Let's consider the experience of countries in which the above models have received the most striking embodiment.

The UK is an example of a developed European country with a predominantly state model of healthcare management. The healthcare system in Great Britain is represented by the National Health Service, which consists of four public health systems – the National Services of England, Northern Ireland, Scotland, Wales. Moreover, each of the systems functions separately from each other, and respectively, the responsibility for the work of each service is borne by the government of the administrative-territorial part of Great Britain, on the territory of which the health service operates. The National Health Service was formed in 1948, and the main principles of its work were and remain accessibility, universality, and free of charge.

Funding for the healthcare system in the UK comes mainly from public funds from taxes to the government budget. In addition, funds from the private health insurance system, as well as funds for receiving paid medical services, can also be sources of funding. Centralized financing of the healthcare system helps to contain the growth of the cost of medical services. Within the framework of this system, the entire population of the country has equal opportunities to receive medical care.

Thus, healthcare in the UK is free for citizens. Each resident is assigned to a general practitioner who writes prescriptions for medicines and refers the patient to specialized specialists when necessary.

The National Health Service provides prevention, primary healthcare, and specialized care services to all British people. However, not all types of services are included in the list of free services. Some of them, if necessary, the patient must pay independently in full, others require social payments from citizens, that is, they are provided subject to the division of the cost of medical services [10].

Thus, in recent years, the UK healthcare system is undergoing some transformations: hospitals are given the status of self-governing, and commercial elements are introduced into their work, namely the offer of paid medical services. Thus, there has been a tendency towards decentralization, since the share of paid services is increasing, and the number of non-state medical institutions and private practicing doctors is also growing. Thus, additional financial resources are attracted to the healthcare system.

A predominantly public healthcare system is also typical for Scandinavian countries. As an example, we chose the healthcare system in Norway. Norway's health governance structure has three subordinate levels: the central government (the country's parliament, the ministry of health), five medical-territorial districts (administrative-territorial divisions called Fylkes covering several provinces), and municipalities (called communes). Central government bodies are also responsible for the development and implementation of the regulatory and legal framework, budget allocation, and are involved in organizing medical care and services in five medical-territorial districts, and 431 municipalities. Specifically, the country's parliament is the state legislature, and the ministry of health is responsible for the health sector at the national level, setting Norway's health policy, organizing reforms, and implementing bills. In addition, the Ministry of Health controls the organization of specialized medical care and coordination in the provision of all other types of medical care, ensuring that they are provided to every resident, regardless of his territory of residence.

Municipalities as independent administrative-territorial units are involved in the regulation of financing and organization of primary healthcare and social services, ensuring citizens' access to health services at their place of residence. They are also responsible for the state of social and living conditions of the population and the state of the environment, as well as health education and recreational activities.

Regional authorities themselves distribute funds allocated to a particular municipality in the field of healthcare, depending on plans and statistical calculations. When covering the levels of a healthcare organization, it should be noted that Norway has a successful policy towards the integration of the latter. In particular, two-state commissions were created: for the legal regulation of medical and social services and the organization of various levels in the healthcare system. By coordinating health and social services and health management levels, the commissions provide the holistic approach to patients that is most needed when working with the elderly and chronic patients.

An important component in the organization of healthcare is its financing. For example, in Norway, the discovery of its oil fields made it possible to ensure the possibility of high government spending on healthcare. The indicator of expenditures in the field of healthcare from the size of the gross domestic product per capita in 2017 was 10 percent. The main sources of healthcare financing are the state budget – 73 percent, social insurance funds – 12 percent, 15 percent are payments by patients, which come from the provision of paid medical services [11, p. 24–28]. In addition, given that Norway has one of the highest GDP per capita values in the world, health expenditures per capita in absolute terms are also significantly higher than in most countries.

Germany is a classic example of a social insurance model. One of the main principles of the German public health system is the division of management powers between the federal government, the states, and the legalized civil society organizations. Thanks to the federalist tradition of Germany, as well as the legacy of the Bismarck social security system, the modern healthcare system in Germany is highly decentralized, with competencies shared at three levels: federal, regional and corporate.

However, different levels of government do not have a dominant role in direct healthcare delivery. These powers are delegated by legislation to local governments. In Germany, there are several specific subjects like medical associations and their unions, for example, the German Medical Assembly, representing the interests of doctors and patients. Its main functions are to exert control over the activities of medical institutions and represent their interests. Unlike Kazakhstani associations, they have real weight (in 2008, the Gematic company, which is responsible for the Gesundheitskarte project, was forced to conduct additional research by the decision of the German Medical Assembly). In Kazakhstani practice, doctors' associations do not have legal representation and enjoy the status of deliberative platforms and forums. While in Germany they have a form of professional self-government, represent the rights of doctors and patients, and exercise public control functions. The decisions of medical associations (for example, the National Medical Assembly) are not imperatives for other subjects of government, but the mechanisms of civil society forced to listen to the opinion of the associations [12].

Since 2009, health insurance has become compulsory for all citizens. There is competition between non-profit, nongovernmental health insurance funds (the so-called statutory health insurance scheme (SHI) that implement compulsory health insurance programs and structures that implement voluntary health insurance programs (private health insurance (PHI) [13]. The main sources of funding for healthcare in Germany are as follows: compulsory health insurance – 60 percent, voluntary health insurance – 10 percent, state budget – 15 percent, personal funds – 15 percent [14].

The United States of America is a prime example of a private model of government and health system regulation.

The healthcare organization system in the United States should be represented by the following structural elements, where the health insurance system – public and private – is the guarantor of the provision of medical care:

Government health insurance programs
The network of state hospitals for military personnel
Local, Municipal, and District Programs
Compulsory private health insurance for employees
Self-payment of medical expenses by citizens

As for the US healthcare management system. The organizational structure of healthcare is characterized by a decentralized healthcare management system with a division of powers between the federal center and the states. The US Department of Health and Human Services is represented as a federal executive body, which, through 27 divisions, implements and controls social programs, in particular, such as Medicare (health insurance for the elderly and disabled) and Medicaid (intended to pay for medical services provided to certain categories of persons with low incomes) [15].

It should be noted that the US healthcare system is predominantly private, and is facing serious problems of uncontrolled growth in healthcare costs (almost 18 percent of GDP). With a high proportion of the uninsured, which is almost 16 percent of the country's population, hospitals are forced to provide emergency care and issue invoices at free-market prices to those who cannot pay for it. With the growth of insolvent debtors, hospitals are forced to raise tariffs to cover their costs at the expense of solvent patients. This is a galloping unregulated rise in prices for medical services. The American economist A. Enthoven says that one of the reasons for the increase in costs is the lack of motivation for savings from medical service providers since market demand creates supply. There is also an excessive supply of services against the background of information asymmetry. As a result, one-third of the funds spent on healthcare is spent ineffectively [16, p. 50].

The combination of elements of the budgetary and insurance models is typical for Singapore. Singapore's healthcare system is recognized as one of the best in the world, and the World Bank encourages countries to learn from Singapore's healthcare experience, taking into account differences in income, demographics, and current healthcare financing systems. Scientists have identified two key elements in achieving such outstanding success in Singapore's healthcare: political stability and a mandatory health insurance system with an emphasis on personal responsibility. The main functions of public administration of the healthcare system are vested in the Ministry of Health of Singapore. The Ministry of Health implements state policy and is also responsible for planning, financing, and staffing. The state is actively pursuing a policy of strengthening a healthy lifestyle, carrying out preventive measures, and developing a system of medical care, thereby motivating the population to become aware of the

responsibility for their health. During the 1980–1990s. all public hospitals in Singapore were transformed into separate legal entities, formally owned by the private, non-profit Singapore Health Corporation, established in 1985, which in turn belongs to the Ministry of Health. Such a complex ownership structure ensured the independence of the hospital management from the Ministry of Health in matters of current activities but retained the Ministry's ability to make strategic decisions to change the structure of the hospital network [17, p. 62–79].

In Singapore, serious control over the quality of medical services has been organized. The function of control over the safety and quality of medicines and devices is performed by a special organization – the Health Science Authority, whose quality and safety assessment criteria comply with the standards adopted in the United States and Europe.

At the time of independence, the state had a healthcare system organized based on the British model: free medical care for the population, provided by a network of public hospitals [18, p. 51], but with the acquisition of the country's independence, Singapore switched to a system of compulsory medical social insurance. Singapore offers universal health insurance for its citizens, with a funding system based on a combination of individual responsibility and universal affordable healthcare. Through the use of market mechanisms to promote competition and transparency and the development of technologies for better quality healthcare delivery, Singapore has achieved excellent health outcomes, with national health spending of about 4 percent of GDP [19].

The healthcare financing system in Singapore has five tiers. The first tier of protection available to all Singaporeans is provided by the government, paying up to 80 percent of the cost of an emergency. The second level of protection is MediSave, introduced in 1984 as part of the National Health Program. MediSave is a national health billing system that helps people keep a portion of their income to pay for future hospitalization, surgical care, and some outpatient care needs, with a personalized medical savings account that allows almost all Singaporeans to pay their share of treatment costs. Under this scheme, each employee contributes 8-10.5 percent of the monthly salary, depending on the age group, to a personal MediSave account. The accumulation rate is 2.5-4 percent, which exceeds the inflation rate in the country.

The third tier, MediShield Life, replaced the MediShield on November 1, 2015. Its goal is to help individuals with chronic conditions who require long-term care, which can drain MediSave over time. As a rule, all citizens of Singapore are automatically eligible for the MediShield Life program, however, they can voluntarily refuse to open this account. The opening of such an account must be no later than the onset of 75 years.

The fourth tier, the ElderShield, approved in 2002, is the government's response to soaring populations over working age. Generally, all Singaporeans are included in this program at the age of 40. The bonus is paid before the age of 65, with the option to transfer funds from the MediSave account.

The fifth tier is Medi Fund that supports low-income citizens to purchase medical services. Obtaining resources from it is possible if it is proved that the income is less than the established minimum. To finance medical services, interest earned on the fund's capital is used [20, p. 177–178].

Today, the problems of healthcare functioning are in the constant focus of attention of the world community, monitoring of the main indicators, characteristics, and directions of healthcare development is carried out. For example, the Bloomberg rating agency constantly monitors the effectiveness of national health systems (Table 1).

Table 1. **Healthcare systems efficiency ranking in 2018**

	Great Britain	Norway	Germany	France	USA	Singapore
Total expenditure (percent of GDP)	9.9	10.0	11.2	11.1	16.8	4.3
Cost of medical services (US$)	4.356	7.464	4.592	4.026	9.536	2.280
Life expectancy	81.0	82.3	80.6	82.3	78.7	82.7
Score	46.3	58.9	38.3	55.5	29.6	85.6
Rank	35	11	45	16	54	2
Note – compiled by the authors according to the Bloomberg rating agency						

According to the American rating agency Bloomberg, Singapore scored 85.6 as the country with the most efficient healthcare system. The average life expectancy of its citizens is 82.7, the cost of medical services is US$2,280, and the level of healthcare spending is 4.3 percent of GDP. Spain is the second, Norway is the third, Great Britain, Germany, the United States are at the 35th, 45th, and 54th positions, respectively. It should be noted that among advanced economies the United States spends the most on healthcare (16.8 percent of GDP), while Singapore's expenses are the least (4.3 percent of GDP) with the life expectancy significantly higher as compared to other countries. According to experts, the success of Singapore in healthcare and other sectors of the public sector is the historical culture of public administration, new technologies, and a system of compulsory health insurance with an emphasis on personal responsibility [21].

It should be noted that the rating had been compiled in a favorable epidemiological situation before the time when the World Health Organization declared the outbreak a Public Health Emergency of International Concern on 30 January 2020, and COVID-19 pandemic on 11 March 2020. Outbreaks of various infectious diseases, epidemics, pandemics are a kind of test on effectiveness for health systems, especially on the ability of state health authorities to quickly respond to the emergency, mobilize as soon as possible and provide the population with timely and high-quality medical care. Following WHO's announcement of the start of a pandemic, the United Nations ranked countries according to their preparedness to prevent a pandemic. The main indicators of the rating, which demonstrate how well a country will be able to cope with the COVID-19 challenges, are the Human Development Index, the state of the healthcare system, and access to the Internet (Table 2).

Table 2. **Ranking of countries for readiness to prevent coronavirus infection**

Countries	Rank	Human Capital Index	State of the healthcare system				Internet access	
			The number of doctors per 10,000 people	Nursing staff	Number of beds	Healthcare expenditure	Mobile comm. per 100,000 people	Fixed broadband internet connection
USA	16	0.920	25.9	86	29	17.1	123.7	33.8
Spain	25	0.893	40.7	55	30	9.0	115.9	32.5
Great Britain	15	0.920	28.1	83	28	9.8	117.5	39.6
Germany	4	0.939	42.1	132	83	11.1	129.3	41.1
Norway	1	0.954	46.3	181	39	10.5	107.2	41.3
Singapore	9	0.935	23.1	72	24	4.5	145.7	28
The authors' compilation based on the UN 2020 Human Development Report http://hdr.undp.org/sites/default/files/hdr2020.pdf								

Table 2 shows that the most prepared countries for the pandemic were Norway, ranked first, followed by Germany ranked fourth, and Singapore ranked ninth. The USA, which was leading by the number of COVID-19 cases (over one million) was ranked the 16th, Great Britain was the 15th (250 thousand cases), Spain was the 25th (232 thousand cases). The main reasons for the high incidence and mortality rate of coronavirus infection in the United States, Great Britain, and Spain were late measures of state bodies to ensure social isolation, the lack of the required healthcare capacities дшлу inpatient beds, medical workers, etc. It should be noted that Germany, Singapore, and Norway were recognized as an example of the effectiveness of government measures taken to combat coronavirus infection [22].

In particular, in Norway, priority government measures were taken to combat the spread of COVID-19 and the consequences of isolation, a social distance was introduced for the population, and a ban was introduced on entry to Norway for foreign citizens who have no legal basis for permanent residence in Norway. A crisis fund of NOK 100 billion has been set up to support economic development in the country.

Germany had developed a special emergency plan long before the pandemic. In 1968, the State of Emergency Act was passed, in 2001 the Infectious Disease Protection Act, which regulates the competence of the federal government and regional authorities for epidemiological surveillance. In addition, the Robert Koch Institute centrally issues updated detailed recommendations for countering coronavirus infection, including both practical steps to protect the population and instructions for the healthcare system, which are followed by all medical institutions in the country.

An inter-ministerial committee on the fight against coronavirus infection was formed in Singapore, which took the following measures: rigorous testing, strict isolation, and contact tracing through digital technologies. It should be noted that Singapore has one of the lowest mortality rates in the world – 0.6 percent.

Conclusions. Thus, based on the study of foreign models of public administration and regulation of the healthcare system, some features characteristic of the OECD countries and Singapore can be identified.

1. In most cases, OECD countries and Singapore are characterized by network management of the healthcare system, which is expressed in the transformation of the role of the state, the transfer of regulatory functions to local authorities, non-governmental and public organizations. At the same time, the main health management body plays a coordinating role and its functions are reduced to the development of a general health policy and providing conditions for the interaction of network structures.

2. OECD countries provide significant funding for healthcare. The share of total health spending in GDP ranges from 9.9 percent (Norway) to 16.8 percent (USA). The United States allocates 16.8 percent of GDP, which is the highest government spending on healthcare, but 78.7 years of life expectancy fails to demonstrate the efficiency of the spending. In Singapore, in contrast to OECD countries, the level of healthcare expenditures in GDP in 2018 was 4.3 percent, which is almost 2 times lower than in most OECD countries, while the life expectancy rate of the population in Singapore is one of the highest in the world – 82.7 percent.

It should be noted that the study of foreign models of public administration and regulation of the healthcare system is necessary to be able to use their experience in Kazakhstani practice. Thus, in our opinion, it would be advisable for the Ukrainian and Kazakhstani models of public administration of the healthcare system to adopt the experience of Germany and Singapore, which are characterized by a developed health insurance system, built on a combination of the principles of individual responsibility and universal affordable medical care, as well as well-coordinated systemic work of public health management bodies in a state of emergency.

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Н. Гражевська, д-р екон. наук, проф.
Київський національний університет імені Тараса Шевченка, Київ, Україна,
А. Тингішева, доктор PhD
Карагандинський університет Казпотребсоюзу, Республіка Казахстан

ДЕРЖАВНЕ УПРАВЛІННЯ ТА РЕГУЛЮВАННЯ СИСТЕМИ ОХОРОНИ ЗДОРОВ'Я В ЗАРУБІЖНИХ КРАЇНАХ

Присвячено порівняльному аналізу моделей державного управління та регулювання системи охорони здоров'я в зарубіжних країнах. Виявлено організаційні особливості функціонування і розвитку систем охорони здоров'я, визначено джерела фінансування охорони здоров'я за трьома видами: бюджетні, страхові, приватні. Особливу увагу приділено сучасному стану систем охорони здоров'я та їхній готовності до запобігання коронавірусній пандемії.

Ключові слова: система охорони здоров'я, державне управління, фінансування охорони здоров'я, коронавірусна пандемія.

Н. Гражевская, д-р экон. наук, проф.
Киевский национальный университет имени Тараса Шевченко, Киев, Украина,
А. Тынгишева, доктор PhD
Карагандинский университет Казпотребсоюза, Республика Казахстан

ГОСУДАРСТВЕННОЕ УПРАВЛЕНИЕ И РЕГУЛИРОВАНИЕ СИСТЕМЫ ЗДРАВООХРАНЕНИЯ В ЗАРУБЕЖНЫХ СТРАНАХ

Посвящено сравнительному анализу моделей государственного управления и регулирования системы здравоохранения в зарубежных странах. Выявлены организационные особенности функционирования и развития систем здравоохранения, определены источники финансирования здравоохранения по трем видам: бюджетные, страховые, частные. Особое внимание уделено современному состоянию систем здравоохранения и их готовности к предотвращению коронавирусной пандемии.

Ключевые слова: система здравоохранения, государственное управление, финансирование здравоохранения, коронавирусная пандемия.

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S. Sviderska, PhD Student
ORCID ID 0000-0003-0179-8838,
P. Kukhta, PhD, Associate Prof.
ORCID ID 0000-0002-0312-8128
Taras Shevchenko National University of Kyiv, Kyiv, Ukraine

THE IMPACT OF INNOVATION ON THE DEVELOPMENT OF THE GLOBAL COSMETICS PRODUCTS MARKET

The article analyzes the state of the global market of cosmetic products, reveals the key importance of investment in research and development for ensuring high growth rates of leading companies in this market. Trends in the field of innovative development followed by the industry are traced with the data of leading companies: Loreal, Estee Lauder, Unilever, Shiseido, Procter & Gamble, and Coty. The main challenges of the environment are outlined and the impact of innovations on the ability of cosmetic companies to function and develop effectively in conditions of the high competition is characterized. The study is based on published materials of leading companies in the industry, including their regulatory documentation, financial and annual reports, etc.

Keywords: innovations, innovative development, competitiveness, cosmetic products market, artificial intelligence.

Introduction. The global cosmetics market is dynamic and quite significantly sizeable. Such characteristics are due to the ever-growing consumer demand, as well as the fact that today this industry is constantly expanding its influence to different target audiences and covers all classes of consumers in terms of their income. Both items are declared in the annual reports of world market leaders – L'oreal, Estee Lauder, Unilever, Shiseido, and others. It is obvious that the availability of the product for consumers with any income level is due to the very specifics of cosmetics, while several factors form the element of expanding the consumer audience: constant mergers and acquisitions, access to new markets, and active innovation. Competitiveness is another characteristic of this market, and innovation plays a key role in ensuring the development of cosmetic companies and is the main means of their growth. Nowadays, innovations form strategic steps for the long-term growth of companies through cost reduction, increasing consumer loyalty, launching and implementing new business initiatives of cosmetic companies. The emphasis on innovation and the introduction of new technologies for market participants increase the recognition of their brand, build brand capital and core sales.

More and more funds are allocated for the development of e-commerce and m-commerce – mobile commerce – a