MEDICAL RESORT MANAGEMENT IN UKRAINE: CHALLENGES AND OPPORTUNITIES

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The problems and prospects of medical and health tourism branch operation in Ukraine, historical preconditions of forming the sanatorium-resort infrastructure and outer business environment are studied. The contemporary state of the development of sanatorium-resort activity is described. The basic sources of differences in organization of recreational complexes in Ukraine and abroad due to the peculiarities of functioning of the national health care system are indicated. The examples of regulation of some elements of the sphere of medical and health tourism in legal documents are represented. The data of state financing of medical and rehabilitation establishments by the countries of the world and the dynamics of ratings by absolute and relative indicators are analyzed. The indexes that characterize the profile of Ukraine in the world market of health services are defined.

Keywords: sanatorium-resort business, medical tourism, recreational complexes, government regulation of health care, financing of medical industry.

УПРАВЛІННЯ КУРОРТНОЮ СПРАВОЮ В УКРАЇНІ: ВИКЛИКИ ТА МОЖЛИВОСТІ

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Досліджено проблеми і перспективи діяльності сектору медичного та оздоровчого туризму в Україні, історичні передумови формування санаторно-курортної інфраструктури та зовнішнього ділового середовища. Охарактеризовано сучасний стан розвитку санаторно-курортної діяльності, вказано на основні джерела відмінностей в організації рекреаційних комплексів в Україні та за кордоном з огляду на особливості функціонування національної галузі охорони здоров'я. Наведено приклади регулювання окремих складових сфери медичного та оздоровчого туризму в нормативно-правових документах, проаналізовано дані щодо державного фінансування медичних та реабілітаційних закладів за країнами світу і побудовано динаміку рейтингів за абсолютними та відносними показниками. Визначено показники, що характеризують профіль України на світовому ринку оздоровчих послуг.

Ключові слова: санаторно-курортна справа, медичний туризм, рекреаційні комплекси, державне регулювання сфери охорони здоров'я, фінансування медичної галузі.

УПРАВЛЕНИЕ КУРОРТНЫМ ДЕЛОМ В УКРАИНЕ: ВЫЗОВЫ И ВОЗМОЖНОСТИ

УДК [338.48-6:615.8](477)

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Исследованы проблемы и перспективы деятельности сектора медицинского и оздоровительного туризма в Украине, исторические предпосылки формирования санаторно-курортной инфраструктуры и внешней деловой среды. Представлена характеристика современного состояния развития санаторно-курортной деятельности, указаны основные источники отличий в организации рекреационных комплексов в Украине и за рубежом с учетом особенностей функционирования национальной отрасли здравоохранения. Приведены примеры регулирования отдельных составляющих сферы медицинского и оздоровительного

туризма в нормативно-правовых документах, проанализированы данные относительно государственного финансирования медицинских и реабилитационных заведений по странам мира и построена динамика рейтингов согласно абсолютным и относительным показателям. Определены показатели, которые характеризуют профиль Украины на мировом рынке оздоровительных услуг.

Ключевые слова: санаторно-курортное дело, медицинский туризм, рекреационные комплексы, государственное регулирование сферы здравоохранения, финансирование медицинской отрасли.

Owing to its geographical, geological structure and hydrogeological conditions, Ukraine possesses traditionally all kinds of resorts. Health and medical tourism may have become the key competitive advantage of the country's tourism economy, but its development was neglected under the conditions of overall recession. Later, when the business environment stabilized and enough funds were accumulated, sluggish regulatory framework of health care could not supply the idea, the concept of a modern product, having resulted in the complete general investment unattractiveness of the sanatorium and resort industry in Ukraine.

The issues of recreation and resort management in the Russian Federation and Ukraine were researched by such scientists as Boyko I. D., Hulych O. I., Ivanunik V. O., Kolesnyk E. O., Kravtsiv V. S., Kuskov A. S., Kyfyak V. F., Lukianova L. H., Preobrazhenskiy V. S., Savranchuk L. A., Smal I. V., Tsybukh V. I., Fomenko N. V., Yarosh M. V., Zakharchenko P. V. and others, but the problem of macroeconomic assessment of the resort sphere and international cooperation in this field should be analysed in connection with the state strategies of foreign and domestic policy.

The scientific novelty of the issue is further development of the analysis of challenges and opportunities of medical resort management in Ukraine based on the experience of some countries.

The main idea is organising management in health tourism branch in Ukraine; the tasks to be solved to achieve this aim are: to define the main contradictions (legal and of the business environment) in the national approach to resort management; to estimate the effectiveness of health protection system in the world; to analyze the indicators of public spending on health by leading countries; to highlight contemporary trends in tourism market forming the demand for rehabilitation services.

In the 1960s of the XXth century, Ukraine had 426 health centres, 154 preventoria, 132 holiday centres and 31 holiday hotels with a total capacity of over 150 thousand seats, and by the end of the 1990s 15 state and 13 local resorts operated in Ukraine. At the beginning of 1994 the resort areas of Ukraine had over 3 600 sanatoria, holiday centres, holiday hotels and other establishments where nearly 700 thousand people could rest.

Intensive resort construction allowed Ukraine to create a system of specialized health centres. In general, their structure is as follows: sanatoria for the treatment of patients with diseases of the cardiovascular system – 22 %; digestive system – 20 %; nervous system – 17 %, respiratory system – 16 %, locomotor system – 17 %, of kidney and urinary tracts – 6.5 %, with diseases of the female breeding organs – 4.5 %; with skin diseases – 0.2 %.

The disintegration of the Soviet Union deteriorated dramatically the situation in sanatorium-resort industry. During the years of Ukraine's independence sanatorium-resort system was hardly paid attention from the state. The lack of budget funding led to a cut in expenditure of government programmes (sanatorium treatment of tuberculosis, traumatic spinal cord disease, postinfarction patients, etc.).

All specialized sanatoria went mainly to seasonal work, many of them minimized their therapeutic base and began to move into the category of recreation facilities with low service quality. Because of the lack of control new establishments (recreation with treatment, health centres, etc.) with a weak medical framework and unskilled staff began to appear.

In general, health-resort system of Ukraine does not form a single system today, although the relevance of spa treatment remains quite high [1]. According to the State Service of Statistics, the number of health centres and health institutions in Ukraine decreased in 2011 comparing with 1990 (only health camps for children totalled 17 703 in 2011 versus 15 687 in 1990) with volatile fluctuations within the researched period (Fig. 1) [2].

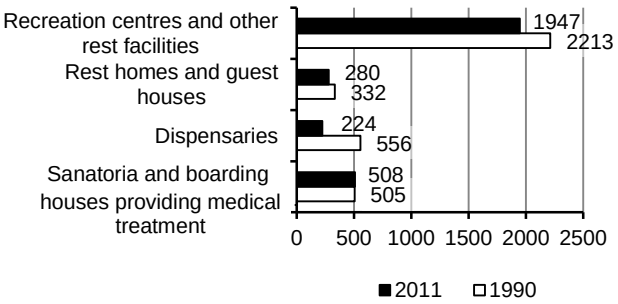

Fig. 1. **Sanatorium-resort and health institutions in Ukraine, total**

The routine which had existed until the late 1980s, has created a situation when the resort "conveyor" had little incentive to develop. The heads of some sanatoria and the industry as a whole faced no task to fill resorts. The demand for recreation was distributed to citizens at regulated prices, excluding the level of service in the world resorts. Since the mid 90s efficient, but obsolete system has lost stability, and many sanatoria faced the classic scenarios of chaos theory. The lack of subsidies from traditional donors – government, authorities, ministries – has led to the cessation of replacement of fixed assets [3].

According to the views of many managers, a resort is a simple set of separate hotels, recreation centres, hotels and travel companies. In their opinion, the problem of a resort is especially the problem of a particular sanatorium. But, in fact, a resort and recreational complex is an integrated system of legal and economic relations; and the resort recreational industry as the object of a national economy is not perceived today by most specialists as an object uniting the efforts of all management units.

Most resorts in Ukraine have several medical factors and are referred to a mixed type: balneo-mud, balneo-climatic, climatic-balneo-mud ones. Ukraine has a rich system of spa services. Spa treatment is held in sanatoria, sanatoria-preventoria (dispensaries), medical centres, holiday hotels with treatment.

Attracting the foreign consumers is restricted by not only the typical problems of undeveloped infrastructure, but also by distinct approaches to the organization of treatment and payment, and, globally, by differences in the fundamentals of medical sciences, the structure and framework of health institutions and supporting facilities. Psychological aspect can also be crucial: a patient prefers to be cured at home, within the common environment, and only extraordinary circumstances may force him or her to go abroad.

Classification and estimation methods of recreational resources sometimes differ a lot, so that it is difficult to compare the potential of several countries and provide permanent hospital and home treatment for a traveller.

For example, when using natural medical factors in Ukraine, the classification of natural and preformed physical factors by Tondiy L. D. and Vasylieva-Lysytska L. Y. is applied (Kharkiv Medical Academy of Graduate Education) [4].

Weather and climate conditions are described by the following indicators: effective temperature (ET), equivalent effective temperature (EET), radiation equivalent effective temperature (REET).

Fedorov-Chubukov weather classification is common in medical climatology in Ukraine and is based on the complex interaction of heliogeophisical and meteorological factors. Classification identifies three main weather groups, which in turn are divided into 16 classes. The scientists of Sechenov I. M. Yalta Research Institute suggested weather assessment scheme of three groups in accordance with the needs of climatotherapy based on the Fedorov-Chubukov classification [4].

Main components, which make the bulk of mineral substances, soluble in water, are not so numerous – in all seven: sodium, calcium, magnesium, potassium, chlorine, sulphates and hydrocarbonates. Quite the contrary, classification criteria can vary from country to country. For example, Directive 2009/54/EC "Of the European Parliament and of the Council of 18 June 2009 on the exploitation and marketing of natural mineral waters" is used in the EU. Sulz C. H. defines 7 groups of artificially prepared mineral waters.

Medical mineral waters, having been explored and used in Ukraine, are aggregated into 6 groups. The main establishment in Ukraine, which studies the influence of mineral waters on human health and asserts recommendations for the usage of these or those springs for medical aims, is the Ukrainian Research Institute of Medical Rehabilitation and Balneology of the Ministry of Health of Ukraine, in Odessa. Chemical composition and uses of mineral drinkable waters are regulated by the state Standard of Ukraine SSU-878-93 "Mineral Potable Waters. Technical Terms" [5].

The main documents of legal character except for the Law "On Resorts" that govern and regulate the issues of resort, natural resources, environmental and land management, are the State cadastre of natural resort areas and the State cadastre of natural medicinal resources. But none of these cadastres has not been consummated till now [6].

The list of resorts in Ukraine and their status (international, national, local) was defined in Annex 3 to the Order on the Procedure of pecuniary valuation of non-agricultural land (except for the lands within settlements) (the Order itself was repealed by the Decree of the State Committee of Land Resources of Ukraine (now the State Agency of Land Resources of Ukraine) No. 19/16/22/11/17/12 dated 27.01.2006), a new version – the Order on the pecuniary valuation of non-agricultural land (except for the lands within settlements) – recognises only the national and local level of resorts, although their list is not given. Obviously international resorts were predisposed to be given the national status [7]. The Decree of the Cabinet of Ministers of Ukraine of 28 December 1996 No. 1576 "On Approving the List of Settlements Attributed to the Resort Ones", establishes the list of resort settlements [8].

The demand for medicinal resources and health institutions development is defined also by the level of medical care and support of the rehabilitation concept both by state and private sector.

At a high level, health services fall into different categories of health care [9 – 10].

1. Primary health care is usually the first point of contact for a patient.

2. Secondary health care means that a primary care person such as a doctor refers a patient to a specialist.

3. Tertiary health care assumes specialized consultative, often hospital care.

Different parts of the world have used different means for health care. The system provides numerous ways of getting funds:

1) government funded (tax paid) national systems;

2) government funded but user fees to top up (often at point of use);

3) health insurance systems (funded by governments, citizens, or some mixture);

4) decentralized, private systems run for profit or not for profit.

A list of options for countries seeking to increase or diversify domestic sources of funding is provided. Not all the options will be applicable in all settings, and the income-generating potential of those that exist will also vary depending on the country (according to "The World Health Report: Health Systems Financing: the Path to Universal Coverage", 2010) [11].

Even richer countries are being forced to diversify their sources of financing, away from the traditional forms of income tax and wage-based insurance deductions. An ageing population means a lower proportion of people in work and wage-based contributions no longer cover the full costs of health care.

Germany, for example, has recently started to inject money from general tax revenues into the social health insurance system through a new central fund called the Gesundheitsfond. The French national health insurance scheme has been partly funded for 30 years by the Contribution sociale généralisée, which includes taxes levied on real estate and capital gains in addition to more traditional forms of revenue such as income taxes.

Poverty not only increases the risk of poor health and the vulnerability of people, it also has serious implications for the delivery of effective health care, including reduced demand for services, the lack of continuity or compliance in medical treatment, and increased transmission of infectious diseases.

Poverty is not just a lack of money. It generally includes the following elements: inadequate income; lack of education, knowledge, and skills; poor health status and lack of access to health care; poor housing; lack of access to safe water and sanitation; insufficient food and nutrition; and lack of control over the reproductive process [12].

Noncommunicable diseases (NCDs) are the leading global causes of death, causing more deaths than all other causes combined, and they strike hardest at the world's low- and middle-income populations.

Of the 57 million global deaths in 2008, 36 million, or 63 %, were due to NCDs, principally cardiovascular diseases, diabetes, cancers and chronic respiratory diseases. As the

impact of NCDs increases, and as population's age, annual NCD deaths are projected to continue to rise worldwide, and the greatest increase is expected to be seen in low- and middle-income regions.

While popular belief presumes that NCDs afflict mostly high-income populations, the evidence tells a very different story. Nearly 80 % of NCD deaths occur in low- and middle-income countries and NCDs are the most frequent causes of death in most countries, except for African ones. Even in African nations, NCDs are rising rapidly and are projected to exceed communicable, maternal, perinatal, and nutritional diseases as the most common causes of death by 2030 [13].

It is now more than a decade since world leaders adopted the Millennium Development Goals (MDGs) and their associated targets. Although progress in settings with the highest rates of mortality has been accelerated in recent years, large variations in health status persist both between and within countries [14].

In 2010, 2 500 million people did not have access to improved sanitation facilities, with 72 % of these people living in rural areas. The number of people living in urban areas without access to improved sanitation is increasing because of rapid growth in the size of urban populations.

A lack of medicines in the public sector forces patients to purchase medicines from the private sector, where generic medicines cost on average 610 % more than their international reference price. Such low public sector availability and high private sector prices drive many families into catastrophic poverty, particularly those with a family member suffering from a chronic NCD.

The trade union movement in different countries led to the revision of the standards, not only labour, but also recreation and health ones, having resulted in formation of the concept of recreational time and has developed sanatoria and resort sector as a tool for rehabilitation. In the Soviet Union there was a practice of sanatorium vouchers redistribution by trade unions at companies and organisations (almost monopolistic structure was created), so that the employee could receive a substantial discount for a voucher. Such approach is implemented today in Ukraine as well, but in a much smaller scale and mostly by public sector institutions.

Following independence, Ukraine created the Federation of Independent Trade Unions on October 6, 1990, which was the successor of the Ukrainian Republican Council of Trade Unions (since 1992 – the Federation of Trade Unions of Ukraine). In December 2005, the Federation of Trade Unions of Ukraine joined the International Confederation of Free Trade Unions [15].

Private joint-stock company of medical and health institutions of trade Unions of Ukraine "Ukrprofozdorovnytsia", founded by the Federation of Trade Unions of Ukraine and the Social Insurance Fund for temporary disability of Ukraine, is the market leader in sanatoria-resort services in Ukraine and comprises over 80 sanatoria-resort facilities located in different climatic regions of Ukraine.The sanatorium rehabilitation supports about 100 branches in more than 20 areas of disease profile, including those for patients with cerebrovascular pathology, old acute myocardial infarction, diseases and injuries of the musculoskeletal system, the digestive system; diabetes, with burn disease, for pregnant women with complications of pregnancy. The purpose of these units is to provide high-quality medical care at the stage of resort treatment after a hospital stay. One of the priorities for the union resort facilities is treatment and rehabilitation of children [16].

Although economic globalisation demands international consolidation of the trade unions, the modern labour movement is really a network of loosely connected national organisations, which continue to operate in accordance with their national problems [17].

Despite the continuation of the trade union movement in the world, a trend of deterioration of working conditions, developed countries including, is not reflected in the jeopardising of ergonomics, but in the free time reduction of an employee, which is characteristic for the services sector (the optimum resort treatment must be 24 days). Together with a legislative confirmation of the right to leave and to a strict set duration of the working day, employees of many companies are forced to solve production issues in their free time to prove their qualification and professionalism (in other words, the ability to cope with a given amount of work, which does not fit into the standard operating day). In many cases, the division of annual leave for a few short periods is explained not by a desire to diversify the employee's vacation, but fear not to handle information received during the absence or the need to coordinate the implementation of a current project, and even the threat of dismissal.

The term "burnout" was coined in the USA in the 70s of the XXth century. In industrialised countries, public interest in the problem of burnout has increased over the last few years [18].

The United States is one of the few industrialised countries that doesn't have a minimum vacation policy. A survey of six countries by Expedia.com found Americans also start out with fewer vacation days – 12 on average – than workers in any other country surveyed. The same survey, conducted by Harris Interactive and Ipsos-Reid, found the average number of vacation days workers receive in the following countries:

France: 39 days; Great Britain: 23 days;
Germany: 27 days; Canada: 20 days;
the Netherlands: 25 days; the United States: 12 days [19].

These new trends increase the significance of psychological recuperation which is sometimes more demanded that the renewal of physical strengths.

According to the World Health Organization (WHO), a well functioning health system responds in a balanced way to a population's needs and expectations by: improving the health status of individuals, families and communities; defending the population against what threatens its health; protecting people against the financial consequences of ill-health; providing equitable access to people-centred care; making it possible for people to participate in decisions affecting their health and health system [20].

The overall level of funding allocated to health sets the boundaries that determine which services will be available to the population. This overall level is determined partly by a country's wealth, the proportion of national income devoted to health, and inflows of funds for health from external partners [14].

The most revealing indicator demonstrating the quality of population's health is a life interval. Usually it is measured by countries with the life expectancy at birth – the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life.

Since 1961 life expectancy in Ukraine decreased from 70.2 to 68.8 in 2012, the highest peak was in 1965 (70.9 years), the lowest – in 1995 (67.1). In general, there were three considerable periods of downturn in the assessment of life expectancy: 1966 – 1979; 1990 – 1995 (the most dramatic one); and 2011 – 68.7 comparing with 70.3 in 2012.

World average made 70 years in 2012, while the minimal and maximal value made 48.2 (Sierra Leone) and 83.2 (San Marino, the last data from 2010) years respectively.

Table 1 represents the countries' indicators. Note that upper margin is taken with decimals, i.e. a country with either 49.9 or 50.6 years of life expectancy will be included into the 45 – 50 interval, and a country with 51.0 or 51.2 years – to the next one [21].

Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation [21]. The world average indicator was 950.4 USD in 2010, while in Ukraine this figure made 234.4 USD.

Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

The world average value was 6.5 % in 2010, in Ukraine public health expenditure made 4.4 % of GDP with 3.7 average (1995 – 2010). Top-20 countries are represented in Table 2. Some countries faced slight fluctuations, but the others had definitely worsen or improved their positions. The world average value of public health expenditure (% of government expenditure) makes 14 – 15 %. Top-20 countries are represented in Table 3, the performance of Ukraine – in Fig. 2 [21].

Table 1

Country groups by the life expectancy indicator (2012 or the last available)

Life expectancy in the countries, years	Number
45 – 50: Mozambique; Chad; Zambia; Central African Republic; Afghanistan; Swaziland; Lesotho; Congo, Dem. Rep.; Guinea-Bissau; Sierra Leone	10
51 – 55: Rwanda; Niger; Malawi; Guinea; Uganda; South Africa; Zimbabwe; Botswana; Nigeria; Cameroon; Mali; Somalia; Angola; Equatorial Guinea; Burundi	15
56 – 60: Ethiopia; Senegal; Tanzania; Mauritania; Gambia; Djibouti; Congo, Rep.; Kenya; Togo; Liberia; Benin; Cote d'Ivoire; Burkina Faso	13
61 – 65: Myanmar; India; Pakistan; Marshall Islands; Turkmenistan; Kiribati; Sao Tome and Principe; Ghana; Cambodia; Gabon; Papua New Guinea; Timor-Leste; Namibia; Haiti; Sudan; Eritrea; Comoros; South Sudan	18
66 – 70: Kosovo; Suriname; Azerbaijan; Belarus; Iraq; Guyana; Trinidad and Tobago; Indonesia; Moldova; Fiji; Bangladesh; Micronesia, Fed. Sts.; Philippines; Palau; Nepal; Korea, Dem. Rep.; Russian Federation; **Ukraine;** Mongolia; Solomon Islands; Uzbekistan; Greenland; Kyrgyz Republic; Lao PDR; Bhutan; Tajikistan; Kazakhstan; Bolivia; Madagascar; Yemen	30
71 – 75: Argentina; the Bahamas; Bosnia and Herzegovina; Slovak Republic; Bahrain; Ecuador; Aruba; French Polynesia; Vietnam; Tunisia; Kuwait; Libya; Macedonia, FYR; Sri Lanka; Malaysia; St. Kitts and Nevis; Montenegro; Serbia; Seychelles; Estonia; Hungary; Saudi Arabia; Turkey; Venezuela; St. Lucia; Romania; Thailand; Cape Verde; Oman; Peru; Georgia; Armenia; Jordan; Bulgaria; China; Nicaragua; Egypt; Colombia; Algeria; Latvia; Iran; Brazil; Mauritius; West Bank and Gaza; Honduras; Jamaica; Lebanon; Dominican Republic; Morocco; St. Vincent and the Grenadines; Samoa; Lithuania; Paraguay; Tonga; Vanuatu; El Salvador; Guatemala	57
76 – 80: France; Norway; Austria; Netherlands; Canada; Ireland; Singapore; Germany; New Zealand; Korea, Rep.; Faeroe Islands; Channel Islands; United Kingdom; Finland; Luxembourg; Greece; Cyprus; Belgium; Malta; Portugal; Bermuda; Slovenia; Virgin Islands (U.S.); Costa Rica; Cuba; Denmark; Chile; Puerto Rico; United States; Isle of Man; Qatar; Czech Republic; Maldives; Albania; Brunei Darussalam; Barbados; Uruguay; Dominica; Croatia; Mexico; Guam; United Arab Emirates; Antigua and Barbuda; Panama; New Caledonia; Syrian Arab Republic; Belize; Grenada; Poland	49
81 and more: San Marino; Japan; Hong Kong SAR, China; Switzerland; Iceland; Italy; Australia; Macao SAR, China; Israel; Spain; Sweden	11

Table 2

Public spending on health, % of GDP (selected countries)

Rank	1995		2000		2005		2010		1995 – 2010 average	
	Country	Data	Country	Data	Country	Data	Country	Data	Country	Data
1	2	3	4	5	6	7	8	9	10	11
1	Marshall Islands	13.38	Marshall Islands	19.85	Marshall Islands	13.22	Marshall Islands	15.02	Marshall Islands	15.28
2	Palau	9.56	Tuvalu	12.34	Timor-Leste	12.37	Tuvalu	14.21	Tuvalu	10.49
3	Kiribati	8.97	Palau	8.50	Micronesia	11.77	Micronesia	12.90	Micronesia	9.51
4	Timor-Leste	8.47	Germany	8.21	Kiribati	10.14	Cuba	9.72	Kiribati	9.17
5	France	8.26	France	8.00	Tuvalu	8.98	Denmark	9.71	Timor-Leste	8.80
6	Germany	8.23	Iceland	7.70	Cuba	8.74	United States	9.49	Palau	8.64

Table 2 (the end)

1	2	3	4	5	6	7	8	9	10	11
7	Micronesia	7.72	Micronesia	7.69	France	8.53	Netherlands	9.45	France	8.45
8	Tuvalu	7.43	Austria	7.64	Palau	8.35	Kiribati	9.26	Germany	8.29
9	Austria	7.04	Kiribati	7.50	Germany	7.95	France	9.25	Austria	7.75
10	Croatia	6.94	Sweden	6.99	Austria	7.92	Germany	8.97	Denmark	7.66
11	Norway	6.93	Denmark	6.81	Iceland	7.68	Austria	8.50	Iceland	7.61
12	Sweden	6.90	Croatia	6.73	Denmark	7.53	Lesotho	8.45	Sweden	7.31
13	Iceland	6.89	San Marino	6.46	Belgium	7.40	New Zealand	8.40	Norway	7.18
14	Uruguay	6.85	Portugal	6.42	Sweden	7.21	United Kingdom	8.08	Cuba	7.07
15	San Marino	6.79	Norway	6.41	Norway	7.07	Belgium	8.00	Canada	6.82
16	Denmark	6.71	Timor-Leste	6.27	Portugal	6.91	Solomon Islands	7.99	Belgium	6.77
17	Canada	6.45	Japan	6.25	New Zealand	6.83	Canada	7.96	United States	6.75
18	Czech Republic	6.36	Canada	6.22	United Kingdom	6.76	Norway	7.95	New Zealand	6.56
19	Hungary	6.13	Slovenia	6.15	United States	6.70	Palau	7.93	Japan	6.46
20	United States	6.09	Uruguay	6.14	Switzerland	6.67	Japan	7.83	San Marino	6.46

Table 3

Public spending on health, % of government expenditure (selected countries)

Rank	1995		2000		2005		2010		1995 – 2010 average	
	Country	Data	Country	Data	Country	Data	Country	Data	Country	Data
1	Nicaragua	27.56	Afghanistan	28.48	Timor-Leste	41.66	Costa Rica	28.99	Costa Rica	23.10
2	Haiti	23.58	Costa Rica	21.67	Andorra	22.01	Samoa	23.44	Andorra	20.63
3	Uruguay	22.24	Panama	21.32	Costa Rica	20.74	Solomon Islands	23.09	Timor-Leste	19.95
4	Costa Rica	20.86	Marshall Islands	21.14	Malawi	19.99	United States	22.35	United States	18.28
5	Bulgaria	19.79	Uruguay	20.47	Switzerland	18.92	Andorra	21.25	Colombia	17.81
6	San Marino	17.84	San Marino	20.44	Honduras	18.76	Uruguay	20.35	Solomon Islands	17.70
7	Montenegro	16.87	Andorra	19.08	Burkina Faso	18.66	Colombia	20.15	Switzerland	17.58
8	United States	16.40	Iceland	18.39	United States	18.48	New Zealand	20.13	Marshall Islands	17.58
9	Suriname	16.15	Germany	18.20	Kiribati	18.40	Rwanda	20.08	Germany	17.49
10	Panama	16.14	Mozambique	17.90	Micronesia	18.25	Micronesia	20.02	Nicaragua	17.32
11	Iceland	16.13	Solomon Islands	17.86	Iceland	18.19	Switzerland	19.90	Iceland	17.19
12	China	15.95	Paraguay	17.51	Rwanda	17.69	Monaco	18.82	Japan	16.93
13	Marshall Islands	15.94	United States	17.10	Colombia	17.68	Germany	18.73	San Marino	16.62
14	Japan	15.66	Montenegro	16.87	New Zealand	17.68	Jordan	18.61	New Zealand	16.48
15	Colombia	15.32	Guatemala	16.65	Mozambique	17.25	Netherlands	18.45	Honduras	16.13
16	Argentina	15.30	Mexico	16.62	Japan	17.21	Japan	18.40	Canada	16.06
17	France	15.18	Colombia	16.44	Ireland	17.00	Vanuatu	18.19	Uruguay	16.01
18	Mexico	15.05	Switzerland	16.03	Germany	16.97	Croatia	17.66	Norway	15.92
19	Germany	15.03	Haiti	16.01	Botswana	16.90	Norway	17.44	France	15.80
20	Kiribati	14.86	Japan	16.00	Norway	16.80	Honduras	17.41	Montenegro	15.74

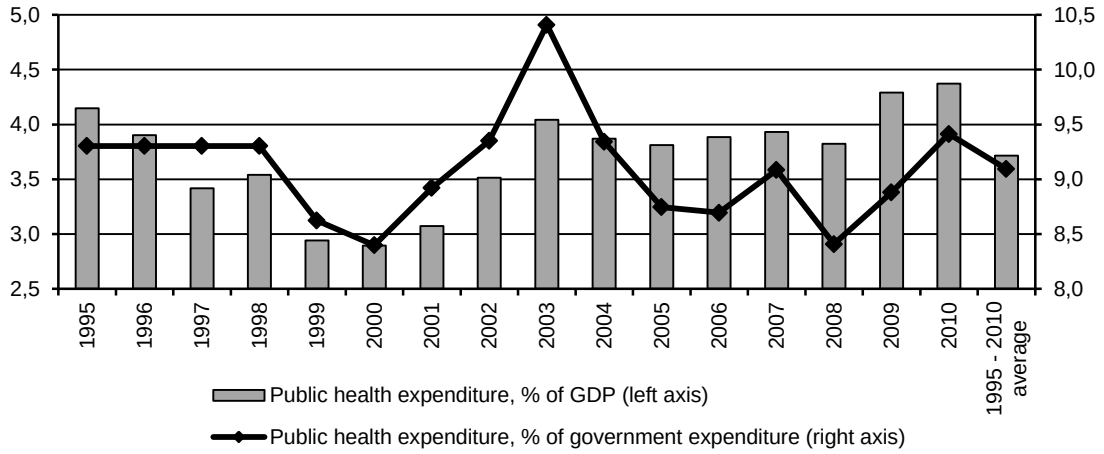

Fig. 2. **Public spending on health in Ukraine**

There are some other indicators which are usually cited at estimation of public health state in a country. They are predominantly processed by the World Health Organization (so-called "global health indicators"). Taken together, these indicators provide a comprehensive summary of the current status of national health and health systems in the following ten areas: 1) life expectancy and mortality; 2) cause-specific mortality and morbidity; 3) selected infectious diseases; 4) health service coverage; 5) risk factors; 6) health workforce, infrastructure and essential medicines; 7) health expenditure; 8) health inequities; 9) demographic and socioeconomic statistics; 10) health information systems and data availability [14].

Increasing numbers of destination countries have enthusiastically marketed themselves as health tourism destinations. The industry is significantly centred in South and Southeast Asia, in India, Malaysia, Singapore and Thailand. Medical tourism has resulted in growing "tourist" numbers and significant income gains in several Asian countries, and widespread enthusiasm from other countries, such as the Philippines and Vietnam, to be involved. The rise of medical tourism raises questions about access to health care in an era of neo-liberal globalization, marked in the health sector by privatisation, deregulation and, especially in the case of medical tourism, commodification and competition. Most ethical debates over medical tourism have centred on such specific procedures as organ transplants, stem cell therapy, reproductive tourism, fertility and surrogacy (some concerns are described in [22 – 26]). All forms of medical tourism raise questions about the appropriate use of skilled health workers, the allocation of financial resources and the distribution of health care. Local population receive less medical services, as specialists prefer to work in private sphere [27].

Definitely new sort of problem emerges when medical tourism is considered just as an additional way of getting income. Patients are attracted by inconsistent, unfounded methods of treatment, often substantiated by reasonable scientific researches. For example, in [28] stem-cell tourism is regarded as ethically problematic because patients receive unproven therapies from untrustworthy sources. Educating patients about the risks of unproven therapies can also help to address the problem of stem-cell tourism. However, education too has significant limitations, since many people will remain ignorant of the dangers of unproven therapies, or they will simply ignore warnings and prudent advice. For many years, cancer patients have travelled to foreign countries to receive unconventional and unproven treatments, despite educational campaigns and media reports discussing the dangers of these therapies. Legal regulations have significant limitations: they apply intranationally, not internationally. If a country passes laws designed to oversee therapy and research, these laws would not apply in another nation. Physicians and investigators who do not want to adhere to these rules can simply move to another country that has a permissive legal environment.

Unfortunately, empirical evidence regarding health and safety risks facing medical tourists is limited. To date, consideration of this issue in the literature is dominated by speculation and reports of individual cases and small case series and lacks meaningful input from clinicians and others with specific expertise in issues of patient health and safety. Much of what is known about the risks potentially faced by medical tourists comes from news media reports. Local research [29] identified five dominant health and safety risks for outbound medical tourists: complications; specific concerns regarding organ transplantation; transmission of antibiotic-resistant organisms; discontinuity of medical documentation and uninformed decision-making.

WHO provides detailed profiles of almost all countries of the world in the sphere of health protection and medical facilities framework, and it is important for a country to possess favourable indicators in order to represent its resort potential. Ukraine should work precisely on its health care system, otherwise it will not gain decent reputation in the market of medical tourism.

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ШЛЯХИ ПІДВИЩЕННЯ ЯКОСТІ ПІДГОТОВКИ КАДРІВ: ГЛОБАЛІСТИЧНИЙ ПІДХІД У КОНТЕКСТІ СТАЛОГО РОЗВИТКУ

УДК 378.371

Гаращук О. В.
Куценко В. І.

Розкрито значення зарубіжного досвіду в підвищенні якості підготовки кадрів та забезпеченні сталого розвитку, показано досвід ряду країн і можливості його використання в Україні. Наведено статистичні дані щодо посилення процесів інтернаціоналізації, інтенсифікації науково-технічного та освітнього співробітництва, дані міжнародних рейтингів університетів. Розкрито шляхи підвищення якості підготовки кадрів: форми співробітництва українських і зарубіжних вищих навчальних закладів; застосування моніторингу якості підготовки кадрів; упровадження інформаційно-комунікаційних технологій у навчальний процес; створення технопарків; розвиток взаємодії вищих навчальних закладів із роботодавцями.

Ключові слова: якість освіти, підготовка кадрів, сталий розвиток, глобалізація, модернізація.

ПУТИ ПОВЫШЕНИЯ КАЧЕСТВА ПОДГОТОВКИ КАДРОВ: ГЛОБАЛИСТИЧЕСКИЙ ПОДХОД В КОНТЕКСТЕ УСТОЙЧИВОГО РАЗВИТИЯ

УДК 378.371

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Раскрыто значение зарубежного опыта в повышении качества подготовки кадров и обеспечении устойчивого развития, представлены опыт ряда стран и возможности его использования в Украине. Приведены статистические данные относительно усиления процессов интернационализации, интенсификации научно-технического и образовательного сотрудничества, данные международных рейтингов университетов. Раскрыты пути