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## Equal access to publicly funded health care services: The legal experiences of Finland and Kazakhstan

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## ABSTRACT

This article deals with the issue of equality in access to publicly funded health care based on the example of two jurisdictions, Finland and Kazakhstan. Legislative provisions of such access differ significantly in these two states. These differences culminate in the notion of citizenship. If Finland guarantees the right to publicly funded health care to everyone who is legally residing within its territory, Kazakhstan departs from that premise in that only its citizens are entitled with such a right. These and other differences led us to enquire into the fundamentals of patient rights in both jurisdictions. We find that both states are facing inequalities of disadvantage regarding access to health care by vulnerable population groups. Both jurisdictions strive towards reducing inequalities in factual distribution of health care services, experiencing the phenomenon of gradual deterioration of public health care. In Finland this deterioration is mostly due to the growth of private actors providing health care services, subsidised partly by the state. In Kazakhstan it is due to the inefficient system of funding medical institutions based on the number of citizens registered within a certain institution.

In our opinion, legal solutions against inequalities in access to publicly funded health care regard, firstly, reconsideration of the status of non-citizens in situations of urgent medical interventions. Secondly, they encourage a shift in official legal doctrine towards fuller recognition of individual patient rights, and the introduction of instances dealing with these rights such as, e.g. a patient ombudsman and independent national authority supervising health care services.

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## 1. Introduction

### 1.1. Equality in access to publicly funded health care: general remarks

From the perspective of individual human rights, equality is 'a right to address the fundamental similarity of human beings as well as differences among them, to eventually target discrimination' (Bayer in Rosenfeld and Sajo, 2012, p. 993). If equality is 'the quality or state of being equal', (Black's Law Dictionary, 2007, p. 576) inequality is, hence, a breach of equality. In this article we deal with the legal implications of inequality in access to publicly funded health care in constitutions and legislation in the legal systems of Finland and Kazakhstan. Systematic analysis of 'health inequalities', i.e. differences in health outcomes among individuals, is left out of our research agenda as such studies belong to the area of social sciences (Machenbach et al., 2008).

Methodologically we follow one of the approaches for comparative legal studies proposed by Walter Hug in his famous publication 'The History of Comparative Law', i.e. we provide an overview of those solutions which various systems offer for a given legal problem (Hug, 1932)<sup>1</sup>. Although Hug's work was published in 1932, the methodology proposed by it is still topical for comparative law studies (De Cruz, 2007, p. 7) as are studies of inequalities in health care (Ingleby, Chiarenza, Deville & Kotsioni, 2012; Kronenfeld, 2008; Bakker and Mackenbach, 2002; Raphael, 2012). We conduct our analysis by comparing the essential points of patient rights and their developmental trends in Kazakhstan and Finland. We depart from a premise that inequalities in access to publicly funded health care can reveal themselves in both insufficient substantive guarantees and ineffective procedural guarantees of such access. This distinction overlaps with the *normative vs. factual* problems implementing patient rights. It also corresponds with the understanding of equality as a concept 'escalating between *recognition* and *redistribution*' which make the issue of equal access to health care both the entitlement 'to be among equals' and the entitlement 'to an equal share' of health care services (Baer, 2012, p. 983).

### 1.2. Jurisdictions to be compared

Comparative legal research on reducing health care inequalities in law is especially topical for Kazakhstan, which strives to construct an efficient system of health care based on examination of the experiences of developed states, especially with regard to the focus on the mechanisms of distributing public expenses in this area (Marat, 2011). Doubtless, Finland and Kazakhstan differ in many respects, e.g. they cover different geographical areas, differ in the size of the population, and lack unification through common regional human rights organisation; they are undergoing different stages of societal and economic development; Kazakhstan relies on codification in its legal system whereas Finland does not, etc. Nevertheless, Finland and Kazakhstan are placed within civil law legal families where legislation is the primary source of law (Kembayev, 2012; Husa, 2015), even though it would be more precise to differentiate Finland in a standalone category within the Nordic legal family due to the 'obvious similarity, as well as historical and geographical connections' (Husa, 2015, p. 228–229) between the five Nordic states (Denmark, Finland, Norway, Iceland, and Sweden). Since these two legal systems relate to the civil law family, we concentrate on the analysis of health care legislation in these two jurisdictions.

Placement within one parent legal family is not the only common denominator between these two selected states. In particular, when it comes to access to health care services, Kazakhstan and Finland take a comparable position in the World Health Care Systems ranking, both being considerably behind top-ten nations (which are: France, Italy, San Marino, Andorra, Malta, Singapore, Spain, Oman, Austria, and Japan (World Health Organization, 2000)). In this ranking our two jurisdictions take a middle position, i.e. Finland is number 31, whereas Kazakhstan is number 64. This middle position indicates the comparability of these two jurisdictions with respect to funding and the actual production of medical services, i.e. both states are distinct for the relatively large role of the state in implementing patient rights by virtue of public medical institutions while the private sector is not yet substantively dominating. As for the shared universal legal standards of health care, we can depart from another common premise: Finland and Kazakhstan are members of the United Nations and therefore are committed to the central UN human rights treaties. In particular, they are committed to Article 12 of the International Covenant on Economic, Social and Cultural Rights (the ICESCR), guaranteeing 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. As far as legal obligations arising from Article 12 of the ICESCR relate, at the major extent, to public health care interventions, we concentrate on the provision of *publicly funded health care services*, omitting several legal relationships concerning individual or private medical care.

Our goal is to study legal implications of (in)equalities in access to publicly funded health care services and legal solutions to deal with inequalities under two different societal contexts. We concentrate on the following issues:

1. Mapping inequalities in patient rights with respect to access to publicly funded health care services in Finland and Kazakhstan;

<sup>1</sup> Hug suggested five possible groups of studies: 1. Comparing national and foreign legal systems in order to find similarities and differences; 2. Analysing solutions which various systems offer for a given legal problem; 3. Investigating causal relationships between various legal systems; 4. Comparing several stages of various legal systems, and 5. Examining legal evolution generally, according to periods and systems.



2. Analysing constitutional foundations of equal access to publicly funded health care services and their specifications in legislation of both Finland and Kazakhstan;
3. Analysing solutions for the problems of inequalities in access to publicly funded health care:
  - a. Creating an overview of the official legal debates regarding inequalities in access to publicly funded health care services;
  - b. Studying available legal remedies to vindicate the right of equal access to such services;
  - c. Analysing on-going health care reforms in the two states under consideration which have a major impact on equality in implementing patient rights.

## 2. Different types of inequalities in access to publicly funded health care services

Not only in developing states, but also in developed European jurisdictions with patient-oriented health care legislation, individuals can lack access to treatment and medicines (Niada-Avshalom, 2015). Since health inequalities 'result from social, economic, gender, racial, and other forms of inequality' (Raphael, 2012, p. viii) intrinsic to many states, the problem of equal access to publicly funded health care services is topical for many states. Although both jurisdictions under consideration face issues of general inequalities resulting from the status of citizenship and specific 'inequalities of disadvantage' (Baer, 2012, p. 983) related to the status of vulnerable groups, these inequalities are illustrated differently.

As for Kazakhstan, inequalities in access to publicly funded health care services are embedded in the text of the 1995 Constitution. In accordance with Article 29 of this Constitution: '[c]itizens of the Republic of Kazakhstan have rights to the protection of health'. This provision is a significantly limited *ratione personae* as compared with Article 12 of the ICESCR, which guarantees the right to the enjoyment of the highest attainable standard of physical and mental health for everyone. Hence, the subgroup of foreign citizens, not to mention stateless persons, is excluded from the opportunity to fully enjoy the right to access publicly funded health care services. Hence, this constitutional provision *per se* institutes inequality. Moreover, rigid state regulation of the health care sector in Kazakhstan, in accordance with which only those diseases which are included in a special inventory upheld by the government are covered by publicly funded health care, provide non-objective grounds for discrimination in access to such health care, depending on the nature of the disease<sup>2</sup>. Finally, dealing with inequalities of disadvantage also becomes a special topic for Kazakhstan in relation to those citizens who were affected by the environmental disasters of the Semipalatinsk Region and the Aral Sea.

As for Finland, Article 19 of its 1999 Constitution does not establish limitations to the right to access publicly funded health care services *ratione personae*. More particularly, this Article 19 reads that: 'the public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population'. At the same time, Finnish legislation establishes the special right of access to health care and to obtain services in Swedish. According to Article 17 of the 1999 Constitution of Finland, 'the national languages of Finland are Finnish and Swedish'. Respectively, various items of legislation contain provisions of access to health care services for Swedish-speaking populations. Moreover, Finland faces specific problems concerning the patient rights of 'paperless persons' who live illegally within the territory of the state and are excluded from enjoying the benefits of publicly funded health care services, excluding urgent ones

Both states face common inequalities which reveal themselves at the factual level of distributing health care services. Such distribution is conditioned by many other factors, varying from the allocation of public funds to organizing voluntary health insurance, etc. Nevertheless, in Finland these elements of fair distribution of health care services are regulated by a number of laws (Lohiniva-Kerkelä, 2007, p. 15–16). In Kazakhstan these issues are regulated primarily by the acts of the government. The still-pending health care reform in Finland is the most recent illustration of factual dependency of patient rights from an efficient procedural mechanism of providing health care services.<sup>3</sup> This reform aims to 'reduce inequalities and to control health care costs' by virtue of setting up 15 social and health care districts, yet the final number of these districts has not yet been negotiated within the present government (Ministry of Social Affairs and Health of Finland, 2015). These districts would be in charge of arranging social and health care services for the population. Today, provision of health and social services is the responsibility of 317 municipal districts (for more information see Association of Finnish Local and Regional Authorities (2015)). Substantively, the reform aims at fuller implementation of the patient right to freely choose a medical service provider. If a person is, e.g. living in a distant suburban area, he or she is still free to receive medical help in private or public clinics located in the city centre. Nonetheless, procedurally this reform proposal causes the reorganisation of provision of health care services as well as redistribution of state subsidies for patients who opted to use private health care services. We return to examining the health care reform in Finland in our subsequent sections.

<sup>2</sup> This registry has been approved by the 2009 Decree of the Government of Kazakhstan and updated in January 2014. Kazakhstan (The Government of Kazakhstan, 2009).

<sup>3</sup> On the current stage of this reform see official statement by the Ministry of Social Affairs and Health of Finland (2015).



### 2.1. Constitutional foundations of equal access to publicly funded health care services

The constitutions of both analysed jurisdictions guarantee the principle of equality before the law. In accordance with Article 6 of the Constitution of Finland, '[n]o one shall, without an acceptable reason, be treated differently from other persons on the ground of sex, age, origin, language, religion, conviction, opinion, health, disability or other reason that concerns his or her person' (Constitution of Finland, 1999). Similarly, Article 14 of the Constitution of Kazakhstan proclaims that: '[n]o one shall be subject to any discrimination for reasons of origin, social class, property status, occupation, sex, race, nationality, language, attitude towards religion, convictions, place of residence or any other circumstances' (Constitution of the Republic of Kazakhstan, 1995). The principle of equality is, nevertheless, reflected differently in our two analysed jurisdictions when it comes to patient rights.

Articles 28 and 29 of the 1995 Constitution of Kazakhstan guarantee the rights to social security and publicly funded health care services (Constitution of the Republic of Kazakhstan, 1995). In accordance with Article 28 of this Constitution, '1. [a] citizen of the Republic of Kazakhstan shall be guaranteed a minimum wage and pension, and guaranteed social security in old age, in case of disease, disability or loss of a breadwinner and other legal grounds. 2. Voluntary social insurance, creation of additional forms of social security, and charity will be encouraged'. Furthermore, the constitutional Article 29 guarantees that: '1. Citizens of the Republic of Kazakhstan have rights to the protection of health. 2. Citizens of the Republic shall be entitled to free, guaranteed, extensive medical assistance established by law. 3. Paid medical treatment shall be provided by state and private medical institutions as well as by persons engaged in private medical practice on the terms and according to the procedures stipulated by law'. On the one hand, this constitutional provision indicates a constitutional entrenchment of the right to access to publicly funded health care services inside the legal system of Kazakhstan. On the other hand, the implementation of patient rights is dependent upon the status of citizenship.

Finland has gone through a similar stage of constitutional regulation of patient rights *ratione personae*, which covered only citizens. Such an approach was prevalent in Finland before an introduction of the 1995 Chapter on Fundamental Rights in the former 1919 Constitution Act of Finland (Husa, 2012, p. 31). Now, Articles 19–22 of the Constitution of Finland of 11 June 1999 refer to rights to social security, responsibility for the environment, and protection of rights under law. Particularly in accordance with Article 19, 'Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider. The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population.' Moreover, in accordance with Article 20 of the Constitution of Finland, 'the public authorities shall endeavour to guarantee for everyone the right to a healthy environment and for everyone the possibility to influence the decisions that concern their own living environment.' Following the provisions of Article 22 of the Constitution of Finland, 'the public authorities shall guarantee the observance of basic rights and liberties and human rights.'

## 3. Equality in access to publicly funded health care services: analysing the provisions of legislation

### 3.1. Kazakhstan

In Kazakhstan specifications for the constitutional right to the protection of health are provided for by Code No. 193-IV 'On the health of the nation and the system of health care'/'*O zdorov'e naroda i sisteme zdravoohraneniya*', adopted on 19 September 2008—hereinafter the 2008 Health Care Code (Code of the Republic of Kazakhstan No. 193-IV, 2008). This code is an extensive item of legislation specifying such issues as the principles of publicly funded health care system, the competence of public authorities in the sphere of health care, licensing and supervision, the financing of the public health care system, the modes and types of concrete medical services, the principles of regulation of drug circulation, the issues of medical research and organ donation, the system of preventive health care, and health care services for vulnerable groups of the population. In accordance with the analysed code, the guaranteed types of public health care include: emergency medical services; first aid; expert consultation and diagnostic services, including outpatient care; the number of hospitalisation cases defined by the competent authority (limited) within the framework of first aid or in-patient care by specialists or medical organisations or emergency indications; rehabilitation; and palliative care and nursing care for special categories of the population in accordance with the decrees of the government of the Republic of Kazakhstan.

Several provisions of the 2008 Health Care Code aim at diminishing general inequalities in access to publicly funded health care services. The code provides that state policy in the area of health care is implemented on the principle of 'ensuring equality of the rights of citizens to receive safe, efficient, and quality medical assistance' (Article 4, para. 1). Several provisions of this code deal with the inequalities of disadvantage. In particular, the code introduces special rights for vulnerable groups of populations: minors (Article 98), mothers-to-be (Article 97), and citizens affected by nuclear disasters (Article 136) and environmental disasters (Article 167). As mentioned previously, the scope of this code extends only to citizens of Kazakhstan. As a general rule, foreign citizens and stateless persons have the right to paid-per-use medical services (Article 35). The law of 22 July 2011 No. 477-IV 'On Migration of the Population' provides that 'immigrants have the right to social and medical help, in accordance with legislation' (Article 5) (Law on Migration of the Population of Republic of



Kazakhstan, 2011). This legislation is Article 88, para. 5 of the 2008 Health Care Code, providing that foreign citizens and stateless persons have the right to publicly funded health care services in the event of urgent disease 'representing a threat to others' (Article 88, para. 5). The same explanation is provided by the Order of the Minister of Health of the Republic of Kazakhstan of 30 September 2011 No. 665, in accordance with which only those diseases which represent a threat for others are treated free of charge for immigrants, other health care services should be purchased on a pay-per-use basis (para. 10) (The Minister of Health, 2011).

Inequalities of disadvantage in Kazakhstan particularly reveal themselves in connection with environmental disasters which necessitate citizens living with proximity to certain regions to acquire stronger health care protection. Environmental disasters cause such impact as increase in mortality, excessive dangerous emissions in the atmosphere, and the devastation of ecosystems. Kazakhstan is still facing the problem of the shrinkage of the Aral Sea as the result of a number of factors, varying from resettling a large number of the population in the early 1930s, the construction of the Karakum channel, and overproduction of cotton during Soviet times. This shrinkage has devastated land around the sea, damaging the health of the population (Zouev 1999). To deal with this problem, a special law was adopted in 1992, i.e. the Law of the Republic of Kazakhstan of 30 June 1992 'On social protection of citizens affected by the Aral Sea ecological disaster'. The purpose of this law is 'to ensure the protection of citizens who suffered as a result of the Aral Sea ecological disaster and to establish measures of compensation and benefits for those in need of social rehabilitation' (Article 1, para. 1) (Law on social protection of citizens affected by the Aral Sea ecological disaster of Republic of Kazakhstan, 1992). Another category of citizens in need of special health care are those who were affected by environmental disasters living in close proximity to the Semipalatinsk region and suffered from the use of nuclear weapon and other deleterious climatic influences. Special measures for health care protection for this category of citizens are regulated by the Decree of the Government of 17 April 2014 No. 362.

### 3.2. Finland

A number of Acts in Finland specify constitutional provisions regarding publicly funded health care: the Health Care Act, 1326/2010; the Primary Health Care Act, 66/1972; the Act on Specialized Medical Care, 1062/1987; the Mental Health Act, 1116/1990; the Act on Health Care Professionals, 559/1994; the Social Welfare Act; the Act on the Status and Rights of Patients, 785/1992. The foundations of health care services are guaranteed by the first enlisted acts—the Health Care Act, 1326/2010 and the Primary Health Care Act, 66/1972. The adoption of the 1972 Primary Health Care Act was 'the most important health care reform of Finland' (Mikkonen in Raphael, 2012, p. 159) which shifted the priorities of the health care system towards the direction of disease prevention and outpatient care.

The general principle of equality in access to health care services is laid down the 2010 Health Care Act, 1326/2010, one of the main purposes of which, according to Article 2, is 'reducing health inequalities between different population groups'. This law also deals with language equality for the Swedish-speaking population. In particular, Article 6 of this law stipulates that: '[b]ilingual local authorities and joint municipal authorities comprising bilingual or both Finnish-speaking and Swedish-speaking local authorities shall make their health care services available in Finnish and Swedish so that clients and patients have access to the services in the language of their choice'. Equality of patients is also guaranteed by the 1992 Act on the Status and Rights of Patients, Article 3 of which guarantees that: '[e]very person who is permanently resident in Finland is without discrimination entitled to health and medical care required by his state of health within the resources available to health care at the time in question'.

With the purpose of reducing possible inequalities in access to publicly funded health care services a number of specific laws have been adopted in Finland, dealing with vulnerable groups of the population. In particular, the recently introduced 2012 Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons No. 980/2012 aims at promoting the equality of the older population. This act lays down a provision for granting elderly people such medical and social services which would 'support the wellbeing, health, functional capacity, independent living and inclusion of older persons' (Article 13). Moreover, the Child Welfare Act No. 417/2007 emphasises children's special position and right to regular health check-ups and care, especially if the state has taken the child into care and provides substitute care (chapter 9). With respect to foreign citizens and stateless persons the Act on Specialized Medical Care lays down provisions on the organization of specialized medical care and related operations (Article 1). Section 3 of the Act specifies that: 'in urgent cases, municipalities have the same obligation regarding the specialized medical care of persons who have no domicile in Finland.'

## 4. Legal solutions for reducing inequalities in access to publicly funded health care services

### 4.1. Intensifying debates of access rights belonging to non-citizens

Accessibility of health care services in Finland also has a special meaning in the context of so-called 'paperless persons', which is a euphemism for illegal immigrants. According to the 2014 estimation, about 3500 illegal immigrant resided in Finland (Keskimäki, Nykänen & Kuusio, 2014, p. 15). The limited resources of Finnish immigration authorities for deporting illegal immigrants open opportunities for many of the latter to remain in the country for several years. A tense public debate arises over the status of paperless persons (for example, Helsinki Times, 2015). Article 19 of the Constitution of Finland



provides that 'those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care', addressing this right to 'everyone' and prescribing that a special act shall be set in order to concretize how to guarantee everybody's right to publicly funded health care services. The Constitutional Law Committee of Parliament (2010) has defined that the urgent health care is inside the scope of art 19, meaning that paperless persons should obtain free urgent health care services. This goal is reflected in Article 50 of the 2010 Health Care Act: '[u]rgent medical care, including urgent oral health care, mental health care, substance abuse care, and psychosocial support shall be provided for patients regardless of their place of residence'.

However, the laws of Finland do not define the decisive term 'urgent care'. Only the decree by the Ministry of Social Affairs and Health, which is an act of subordinate legislation, mentions that 'urgent services' imply services which a patient requires within 24 h in order to avoid a drastic worsening of the condition (Keskimäki et al, 2014, p. 24). The problem of equality is hereby illustrated by the fact that an act of subordinate legislation, which is not the law, introduces a limitation of basic rights. At the same time, the jurisprudence of the European Court of Human Rights implies that the arguments for access of non-citizens to general, i.e. non-urgent health care, should be interpreted narrowly (Keskimäki et al, 2014, p. 46–55). The Court does not emphasise that the states should provide full-scale non-urgent health services to illegal immigrants. Especially clear is the statement by the ECtHR in the 2001 case of *Cyprus v. Turkey* (2001). In par. 219 of this case the Court observes that 'an issue may arise under Article 2 of the Convention (i.e. *the right to life—the authors*) where it is shown that the authorities of a Contracting State put an individual's life at risk through the denial of publicly funded health care which they have undertaken to make available to the population generally. It notes in this connection that Article 2 § 1 of the Convention enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction ...'. The problem is serious, as the ability of an illegal immigrant to complain about his treatment and seek remedies if his access to health care is unlawfully denied is weak. At the same time, the European Committee of Social Rights, monitoring the implementation of the European Social Charter, in its conclusions on Spain claimed that 'the States Parties to the Charter have positive obligations in terms of access to health care for migrants, "whatever their residence status"' (Council of Europe, 2013).

The awareness about this ethical problem has led doctors in major cities to join and form voluntary associations to provide free health care services at non-public clinics to illegal immigrants (Vierula, 2011; Hankonen, 2013). This activity is most established at Helsinki Global Clinic (Government of Finland, 2014). In addition, the city of Helsinki also provides illegal immigrants with the same standard of care as asylum seekers, who are entitled by law to health care services on the basis of their status (Finish News Mass media cooperation YLE, 2013). Such approach confirms the preventive ideology of Finnish health care, i.e. it is much more cost effective to treat illnesses on their early stages. Finally, refusals to treat illegal immigrants during basic working hours increases the load on outpatient care (Keskimäki et al, 2014, p.26–28). One can justify these initiatives with the goal of 'promoting the health of the population', which is a positive obligation imposed on public authorities by Article 19 of the Constitution of Finland. These ideas are so far not reflected by the health care legislation of Kazakhstan, which guarantees health care services for non-citizens only on a pay-per-use basis (Article 35 of the Health Care Code of Kazakhstan).

Finally, the idea to promote access for illegal immigrants to publicly funded health care services in Finland, besides its humanitarian aspect, is connected to the efforts aiming to stop the spread of contagious illnesses. At least this kind of logic is also present in the 2008 Health Care Code of Kazakhstan, which provides that urgent public health care is provided for foreigners and stateless persons if there is a threat of spreading illnesses to others.

## 4.2. Looking for efficient remedies to restore equality

### 4.2.1. Efficient system of health care administration

4.2.1.1. *Finland.* Today, the health care system of Finland can be characterized as being patient-centred (Tannenbaum, 2015, p. 273). Reducing poverty, inequality, and social exclusion are among the top priorities for the Ministry of Social Affairs and Health of Finland. In 2008 the Ministry adopted the National Action Plan to Reduce Inequalities 2008–2011 (Mikkonen in Raphael, 2012). The most recent governmental initiative, aiming at reducing health care inequalities is the programme 'Socially Sustainable Finland 2020' which aims at reducing differences in health (Mikkonen in Raphael, 2012). The Finnish health care system presupposes a mixed model of producing and funding health care services. It is mixed in the sense that there are both public and private health service providers while the private providers receive funds from public sources, especially from the National Health Care Insurance Agency, *KELA* (Teperi, Porter, Vuorenkoski & Baron, 2009, p. 37, 38, and 40). Only 10% of doctors are employed on a full-time basis in private hospitals and clinics, yet the system is mixed also in the sense that 30% of doctors work for both public and private employers (Teperi et al, 2009, p. 51–54).

There is a two-tier insurance system in Finland, i.e. the state both covers all individuals who stay legally in Finland with compulsory public health insurance and compensates a part of treatment if a patient opts for private clinics if the patient does not have private medical insurance. From the standpoint of equal access to publicly funded health care services the shift towards patient rights means that individual access to such services should be fully respected amidst the processes of a gradually deteriorating public health care system covered by compulsory medical insurance, accompanied by the growth of the private health sector accessed on the basis of private insurance (Gill and Bakker, 2006, p. 43–44). Previously, health care law and politics in Finland were dominated by the public production of health care services. Ideologically the focus on patient rights, constitutional ones included, helps to articulate the new liberal order of things. Because the patient has a right to a health care service



and a freedom of choice, it becomes possible to encourage that his or her choices over who provides the service should be primary. The globally influential neoliberal dogma has it that the best social mechanism to provide maximum individual choice is not by the assumption of a public institution but a free market of private actors driven by mutual competition (Gill and Bakker, 2006, p.38–39). In other words, in the liberal mind set the fulfilment of patient rights does not ask primarily who provides the service to fulfil the right, only who can do it most efficiently by providing the most satisfying alternatives to choose from. This trend of upholding the two-tier system of medical insurance in Finland can contribute in the enhancement of wealth-based discrimination in access to health care in the future (National Institute for Health and Welfare, 2015). Finland is already among those industrialised countries where sex and education-based health differences, correlating positively to wealth, among population groups were placed the 21st highest in an OECD (2013) survey.

Administering the health care system in Finland rests on the principle that the role of the government and the ministries in the sphere of health care is coordination, while the actual provision of public health care services is carried out by the municipalities or by virtue of inter-municipal co-operation. In this respect, noteworthy are the activities of *Valvira*, the Finnish National Supervisory Authority for Welfare and Health, which seeks to improve the quality of medical services. This Agency was set up in 2009 in accordance with Article 2 (a) of the 1992 Act on the Status and Rights of Patients. Following this Article, the goal of *Valvira* is 'to deal, at the level of principle, with ethical issues relating to social welfare and health care and the status of patients and clients as well as to issue recommendations concerning them'. These days *Valvira* provides guideline on how health care service providers should carry out their own self-monitoring and assessment of quality (Kotkas, 2013).

**4.2.1.2. Kazakhstan.** Kazakhstan presently relies on compulsory health care insurance while allowing private individual medical insurance. Such a system of health care insurance was introduced in 1995 by the Edict of the President of Kazakhstan No. 2329 'On medical insurance for citizens'. This system proposed the coexistence of compulsory medical insurance, covering the basic service for citizens and optional private insurance, allowing the receipt of extra medical services not covered by the compulsory insurance. The process of maintaining the system of compulsory insurance was coordinated by the Foundation of Compulsory Medical Insurance, which was a non-commercial state organization. The idea of compulsory medical insurance meant a significant step towards diminishing health inequalities as it emphasised the urgency of compulsory health care insurance for all citizens of Kazakhstan irrespective of their financial capacity to purchase private medical insurance or obtain private medical services. Yet until the introduction of the 2008 Health Care Code the two-tier nature of the medical insurance scheme existed mainly on paper, i.e. the state did not emphasise the meaning of optional medical insurance. Article 31 of the 2008 Health Care Code guaranteed that the system of health care in Kazakhstan includes state and non-state sectors (para. 1). The state sector combines state organs and state medical institutions, whereas the non-state sector includes private medical institutions and individuals engaged in private medical and pharmaceutical practices (paras. 2 and 3). The state, however, maintains a special inventory of diseases, such as, e.g. serious psychiatric disorders, the treatment of which is prohibited in the private sector (Minister of Health, 2009).

Modern Kazakhstan faces systemic difficulties in providing equal access to publicly funded health care, similar to those of Finland, i.e. a lack of due competitive relationships between the public and private providers of health care services. Public medical institutions undergo deterioration as they get their financing from the state merely from the fact that a certain number of patients registered as their clients. Another problem is related to a lack of qualified personnel. When a clinic is short of qualified medical personnel, the administration has difficulties in sending the personnel to professional training courses, which negatively influences the qualification of the latter (Aarva, Pileska & Kalogeropoulos, 2011). Moreover, unsettled is the issue of providing health care services in remote, loosely populated countryside areas.

As for administering the health-care system, the national system of Kazakhstan can be classified as a governmentally coordinated system with a planned transition to a further accentuation of market-based regulatory mechanisms. Although it is centralized, it has its positive characteristics. In particular, 'the state regulation in the field of social development in Kazakhstan is strong, but it allows quality non-state sector to operate in the market' (Aydarov, 2012, p. 243). The competent authority for administering health care services and accreditation in this sphere is the Ministry of Health and Social Development of the Republic of Kazakhstan. Nevertheless, the independent organizations formed from independent specialists—such as the *Valvira* in Finland—would increase the quality of the monitoring and accreditation. When it comes to compensating expenses related to specific diseases, a special inventory, maintained by the Government of the Republic of Kazakhstan, becomes relevant (Government of the Republic of Kazakhstan, 2009). Only those diseases which are listed in this register are covered by publicly funded health care services. The amount of the guaranteed free medical care to the citizens of the Republic of the Kazakhstan is given in the expense of the budget in accordance with this list, approved by the Government of the Republic of the Kazakhstan, which covers the most common preventive, diagnostic, and therapeutic medical services. This is, obviously, a limitation of the right to free medical aid as the scope of actual publicly funded health care services is defined, not in accordance with the law, but following subordinate acts of the government which outline the foundations of free health care services. Doubtless, health care services, medicines, and medical equipment should be accredited in accordance with Chapter 3 of the 2008 Health Care Code. The amount of particular publicly funded health care services provided by the public sector increases annually<sup>4</sup>.

<sup>4</sup> See, the data on per capita government expenditure on health at average, reproduced in the collection of WHO Statistics summary on Kazakhstan (WHO, 2014). This per capita rate has been steadily growing: 194 USD in year 2009, 235 USD in year 2010, 265 USD in year 2011, 301 USD in 2012, and 308 USD in year 2013.



#### 4.2.2. Special authorities to deal with patient rights

Before possibly reaching the courts of law, the violated right of equal access to health care can be vindicated in the framework of administrative procedures implemented via special authorities. When it comes to Finland, the 1992 Act on the Status and Rights of Patients introduced a special authority dealing with violations of patient rights, i.e. a patient ombudsman. Following Article 11 of the analysed law, the patient ombudsman 'shall be appointed for health care units'. The tasks of the patient ombudsman are: advising patients in issues concerning the application of this Act; informing patients of their rights; and acting otherwise for the promotion and implementation of patient rights. Two or more medical institutions may share a common patient ombudsman. The patient ombudsman is, however, not charged with the function of assisting the individuals in submitting court complaints on violations of patient rights. This is a significant limitation of the mandate of the patient ombudsmen *vis-a-vis* the functions of the national non-discrimination ombudsman set up by the 2014 Non-Discrimination Act of Finland 1325/2014.

Perhaps due to the fact of a weaker entrenchment of the ideas of patient rights in the legal system of Kazakhstan, such a specialized authority as a patient ombudsman is unfamiliar to its legal system. Citizens can also address violations of equal access to publicly funded health care services to the regular ombudsman. Yet such a procedure would be less effective due to the greater number of cases which the ombudsman would have to deal with. Under the aegis of public authorities of major regions of Kazakhstan exist consultative councils on the protection of patient rights. Yet the functions of these councils refer to consideration of the reports submitted by public functionaries charged with the issues of administering the health care system (Almaty, the *Maslikhat* of the Fifth Convention, 2012). Nevertheless, the Ministry of Health and Social Affairs of the Republic of Kazakhstan is currently pursuing the establishment of a permanent commission on monitoring the quality of publicly funded health care services, which would also take individual applications on violations of patient rights. President of Republic of Kazakhstan (2015).

#### 4.2.3. Judicial protection

Finnish courts supervise patient rights and monitor the process of health care management. However, judicial protection of patient rights is a relatively young phenomenon. Until the late 1970s, Finnish courts rarely engaged in any 'patient – health care provider' disputes. The courts saw health care as a rigid state-steered system, which again resembled the system of early 1990s in Kazakhstan. The rationality of such a system is instrumental, i.e. it served to promote solidarity for health care authorities. Nowadays, the system of protecting patient rights in Finland is different. The change towards the client-oriented approach started with tuning the prevalent ideology of patient legal status and rights. As a result, in the 1980s the courts in Finland began to take a critical distance from the opinions of experts in the health care system and concentrated on the essence of individual rights when considering disputes regarding the delivery of health care services. Still, in the 1970s, challenging a doctor's opinions and the provisions of health law statutes was rather taboo in the Finnish courts. During the next decade the Supreme Administrative Court of Finland took a new course. It delivered the decision against the unanimous opinion of several leading psychiatrists, on the basis of which a patient, having a severe psychiatric diagnosis, should be released to an open health care instead of being kept in a closed one, as was the opinion of the doctors (Case record number 6414/1986). The judgement of the Supreme Administrative Court referred directly to the patient's constitutional right to freedom of movement. As noticed earlier, formally a special category of patient rights was extensively recognized in the statutory law only in the 1992 Act on the Status and Rights of Patients. As a result patient rights became derivatives from constitutional rights. After the forefront decision of the Supreme Administrative Court and the 1992 Act the Finnish courts affirmed their competence to create new case law in the area of patient rights. In 2002 the Supreme Administrative Court delivered another landmark case which articulated the patients' right to choose not only the public but also private health care providers in the case of an emergency and the right to compensation of the expenses with the higher public subsidy rate. Hence, patient rights were directly distilled by the Finnish courts from constitutional rights. In particular, the 2002 judgement of the Supreme Administrative Court outlined a clear 'patient centred' limit for a significant public budgetary discretion competence.

When it comes to the contribution of the courts of general jurisdictions, they developed a body of tort case law, enabling patients to look for fair compensation in medical malpractice events. One can also recognise a very similar basic trend, i.e. straight reasoning on the grounds of patient rights in the European Court of Justice (ECJ) case law. In the late 1990s and early 2000s the ECJ proclaimed the patient right to cross-border health care<sup>5</sup>. These rights were further incorporated in the 2011 EU Patient's Rights Directive (2011), guaranteeing patients with the right to reimbursement of the cost of cross-border healthcare in order to obtain health care services in other EU member state (Article 5), 'if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation' (Article 7).

As far as Kazakhstan, citizens can protect their right of equal access to health care, based on the provisions of the 2008 Health Care Code to the courts of general jurisdiction. Article 88, para. 10 of this Code provides that harm, inflicted on patients by undue prescription and use of medication and medical equipment is subject to compensation. The courts define

<sup>5</sup> ECJ, Joined cases 286/82 *Luisi and Carbonare* [1984] ECR377; case C-158/96 *Kohll* [1998] ECR I-1931; case C-368/98 *Vanbraekel and others* [2001] ECR I-5363; case C-157/99 *Smits and Peerboms* [2001] ECR-5473; case C-385/99 *Müller-Fauré and Riet* [2003] ECR I-4509; case C-372/04 *W* [2006] I-4325; case C-208/07 *von Chamier-Glisczinski* [2009] ECR I 6095. On the developmental line see: (Cruz in Willem et al, 2011).



the amount of the compensation on the basis of Article 917 of the Civil Code of the Republic of Kazakhstan. Nonetheless, there are not many court cases regarding such compensation (Zhapparova, 2012). A relatively low number of court cases on patient rights testifies to a poor entrenchment of the idea of patient rights in the legal system of this republic.

#### 4.3. New direction for health care reforms

##### 4.3.1. Kazakhstan

Overall, Kazakhstan's legislation in the area of health care services is subject to significant changes through the periodic introduction of new modes of managing the health care system. One of the newest channels for state control is the creation of the joint-stock company National Medical Holding 'with 100% participation of the state in its authorised capital', which was established by Proclamation No. 451 of the Government of the Republic of Kazakhstan of 13 May 2008 (Zhatkanbayeva, 2014, p. 56–61).

On-going health care reform in Kazakhstan has passed through several phases. After having gained its independence from the Soviet Union, Kazakhstan was left with a clumsy post-Soviet health care system accommodating the overwhelming number of public medical institutions with qualified medical personnel but operating with old equipment. In the period of 1991–1996 the Ministry of Health was charged with the functions of administering the sphere of health care. Amidst the shortage of financing and the extensive immigration of specialists abroad, the Ministry undertook efforts to provide the citizens of Kazakhstan with a guaranteed set of public health care services. Such administration was based on the principle of adapting the health care system towards the principle of free market relationships. The year 1995 marked an introduction of a new two-tier insurance system, introducing a combination of compulsory and voluntary insurance schemes. Entrenchment of compulsory insurance for all citizens meant a step towards diminishing health care inequalities based on employment.

In 1998 the Ministry of Health elaborated the first state programme 'On the Health of the Nation', which is still being implemented within the framework of the Strategy of Development of Kazakhstan, entitled 'Kazakhstan-2030'. The programme was targeted on the following elements: (1) undertaking of complex measures aimed at the development of the system of health care services, as well as adapting the health care system towards open market mechanisms; (2) ensuring economic and legal guarantees for the creation of the inner market of medical services; (3) enhancing the efficiency of the medical institutions and optimizing the quality of health care services; and (4) accountability of the state as well as participation of the citizenry and employers in the process to strengthen health. Actual implementation of this programme revealed serious problems not only relating to the sphere of health care but to the organization of water supplies, control of imported food items, and the monitoring of the environment (Strategic Plan of the Ministry of Health of the Republic of Kazakhstan for 2010–2014, 2010). None of the goals of the programme has been properly achieved.

The next phase of health care reforms in Kazakhstan was elaboration of the state programme for the reformation and development of health care in the Republic of Kazakhstan in 2005–2010. This programme, inter alia, introduced a guaranteed basic set of public health care services which is still topical for Kazakhstan and defined the principles of sharing health care system between the public sector and the individual health care sector (President of Republic of Kazakhstan, 2004). This programme introduced a new principle for publicly financing medical institutions based on the number of patients receiving the services. In other words, after that reform the more citizens registered as clients of a polyclinic, the higher sum this polyclinic receives from the state. In order to avoid possible misuses of this system, the programme strengthened the process of monitoring the quality of delivering health care services by introducing penalties to be paid by medical institutions for violations. This system preserved the compulsory medical insurance. This programme also prioritized such areas of public health care as the introduction of free provision of medicines, rehabilitation of children, pre-natal care for women, neurosurgery, outpatient medical services, cardiology, quotas for assisted reproduction, and involuntary treatment of sexually transmitted diseases that represent the danger for society.

The new government programme document, entitled 'Kazakhstan–2050' posed new goals in the area of health care: providing *quality and accessible* medical services, diagnostics and treatment of the maximum spectrum of diseases, enhancement of preventive health-care, the ensuring of all individuals who have not reached 16 years of age with a full set of free medical services, and legislative guarantees of the minimum living standards. Respectively, currently Kazakhstan is implementing the state programme 'Salamatty Kazakhstan 2011–2015', based on two key principles, i.e. quality and accessibility of health care services and targets increasing birth rates, prolonging life expectancy, decreasing infant mortality, and decreasing the spread of HIV. In particular, this programme focuses on the accessibility of health care services for the inhabitants of the remote countryside.

Another novelty in the area of health care is the redistribution of health care costs between the state and the employers. Since 2015 Kazakhstan obligates employers to pay 3% of the salary costs as compulsory medical insurance payments.

**4.3.1.1. Finland.** The modern era of patient rights started with the adoption of the 1972 Public Health Care Act. It obligated municipalities to organize a wide range of health care services to be accessible in one location. Prior to this Act, Finland attempted to guarantee sufficient health care services for as many members of society as possible. The need for reforms was urgent. For instance, by the late 1960s, at 40 years, the life expectancy for Finnish men was the lowest in Europe (Teperi et al., 2009). Hence, during the 1970s and 1980s an overwhelming share of public funds was allocated to the development of publicly funded health care (Holm, Liss & Frithjof Norheim, 1999, p. 321–322). The reforms resulted in the creation of many



public medical institutions and the introduction of compulsory publicly administered health insurance covering all citizens (Holm et al., 1999, p. 321–322). The private health care service providers were an option for wealthy individuals, not a means to provide the most necessary services to citizens, which meant the inequality of the privileged. The health care market as well as the public health care sector were tightly regulated and supervised by public authorities. Tight supervision by licensing then covered and still covers medical products (medicines, equipment), services (diagnostic and therapeutic), medical professions (doctors, nurses, and other therapists) and the supervision of institutional players (various public and private hospitals, private health care companies, public and private health insurance companies, etc.).

When it comes to the most recent administrative reforms in the area of health care, the key idea is to merge the 1992 Act on Patient Rights and the 2010 Health Care Act into one document. This reform mostly focuses on increasing patients' freedom to choose a service provider. In fact, this reform plans to set up 15 new health and social care production districts in order to produce public services/to subcontract with private producers. These districts will substitute the present system of health care services provided by 317 municipalities. The 2013 and 2014 reform proposals by the government have been rejected by the constitutional committee of the parliament. According to the decision of this Committee, the proposals to set up a new service do not exactly match the constitutional right to self-government entitling municipalities to make decisions in the area of health care and social service-related budgeting (Constitutional Committee of Parliament, 2015). Presently, the Government of Finland is elaborating another proposal for organizing social and health care districts giving more consideration for the issues of local democratic representation (Reuters, 2015). This reform, hence, reflects the trend of the neoliberal idea, according to which health care should be organized by the internal forces of market supply and demand instead of regulation by state.

*4.3.1.2. Concluding observations.* Although inequalities in the access to publicly funded health care services reveal themselves differently in Finland and Kazakhstan, legal regulation of equal access to such services in the analysed jurisdictions is comparable with respect to their taking account of vulnerable population groups. Nevertheless, the provisions of legislation in these two states differ significantly in their approach towards access to publicly funded health care services by non-citizens, which is a trend reflected by the constitutions of the both states. Having reviewed constitutional and legislative implications of inequalities in access to health care in Finland and in Kazakhstan, we can see that the major difference in the constitutional formulations is in the scope of constitutional protection *ratione personae*. While the Constitution of Kazakhstan guarantees the right to health only for Kazakh citizens, the Constitution of Finland claims that everyone shall be guaranteed with access to health care services.

These discrepancies can be addressed to different stages of disseminating the ideas of patient rights in two analysed states. Finland became accustomed to the topic of patient rights since 1992 when its higher courts started to deliver patient-friendly judgments. Nonetheless, spreading the neoliberal values of patient rights is difficult to put forward both in Finland and Kazakhstan. This can be explained by the fact that both analysed legal systems were historically influenced by large scale public service production and respective planning, obligatory licensing, and supervision of health care service providers by public authorities. Even though Finland has already turned its legal ideology towards the direction of patient rights, Kazakhstan is still lacking similar ideas in its legal system.

The distributive or factual aspect of equality in access to publicly funded health care services rests mostly in the sphere of policy-making and implementing laws. The laws of Finland stipulate many solutions for vindicating violated patient rights. These remedies vary from the right to complain to the health care provider's supervising authorities (such as the *Valvira* agency and the patient ombudsman) to the right to fair compensation in the case of tort-based damages through the court. Kazakhstan would benefit from introducing a patient ombudsman or a national supervising authority like Finland's *Valvira*, which would facilitate decentralisation and more efficient supervision of health care services. At present Kazakhstan's Ministry of Health is the organ in charge of all issues in the field of health care: licensing, providing services, supervision, and control.

Overall, the adoption of the 2008 Health Care Code in Kazakhstan solved many contradictions that existed in the previous multiple items of health care legislation and systematised legal rules in this sphere. Nevertheless, if this code is aimed at the regulation of health care and medical services by emphasising the competence of the government, the health care acts of Finland are client-oriented in their emphasis on ensuring and protecting the rights of the patients. The trend to provide equal access to health care within the mechanisms of a free market economy is still on the agenda in Kazakhstan. It is therefore necessary for Kazakhstan to continue development in the area of the health care system.

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