ECONOMIC PROBLEMS OF HEALTH SERVICES SYSTEM REFORM IN RUSSIA

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This paper focuses on issues of carrying out reforms in financing health services in the Russian Federation after the financial crisis of August 1998. The main problem faced by the Russian health services system in an aggravated economic crisis is lack of financial backing of government guarantees of free medical care to citizens. From 1991 through 1998, public spending on health care shrank by 33 percent in comparable terms, while government guarantees of free medical care to citizens remained unchanged.

The nature of the further evolution of the health services financing system, particularly the mandatory medical insurance system (MMI), will be dependent on the method of resolving this problem. To ensure a balance of financial resources and liabilities in the health services system, government guarantees in health services and social insurance should be reconsidered. The paper gives scenario assessments of the level of financial backing of government guarantees of medical services to citizens, and reviews possible ways and means of restoring consistency between government guarantees and their financing.

Introduction of MMI in Russia was viewed not just as a means of improving health services financing but also as a means of improving the quality of medical care through the development of manageable competition and expanding the range of choices for patients. The further development of the MMI system requires a set of measures targeted at removing the diarchy and duplication in the MMI management, introducing countrywide capitation formula financing of insurance medical organizations from the MMI funds, strengthening requirements to medical insurance organizations, expanding insurance companies' participation in the management of providing medical care to the insured, and at providing transparency of financial flows in the MMI system.

1. Introduction

A shift from the budgetary system of financing to the MMI system is the pivot of reforms of health services in Russia in the 1990ies.

From an economic standpoint, Russian health services system at the end of 1990ies is characterized by two key problems:

- lack of balance between government guarantees of providing free medical care and their financial backing;

- incompletely introduced insurance system of financing the health services system; eclectic combination of elements of the old and the new financing systems.

Introduction of medical insurance was viewed primarily as a means of obtaining guaranteed sources of financing and increasing flows to health services. Employers' contributions in part damped a large reduction of budget allocations. While government spending on health services went down less dramatically than on culture and education, these amounts are not enough to support the existing network of medical institutions.

Medical insurance was introduced with another important goal in view, i.e., to improve the efficiency of the medical care system. To reach this goal, the following guiding principles were expected to be kept to:

- institutional separation of those who provide medical services and those who pay for them;

- to encourage competition between service providers for receiving finance;

- to encourage competition for contracting citizens' money between buyers who would act as intermediaries between citizens and medical institutions;

- to ensure patients' right to choose the doctor, medical institution, and intermediary.

The initial concept of reforming the health services system implied that an MMI model would be introduced, with private insurers' competition as buyers of medical services. The RF Law *On Medical Insurance of the Russian Federation Citizens*, passed in 1991, states that insurers in the MMI system are medical insurance organizations. In 1993, the RF Supreme Soviet allowed branches of the territorial MMI funds to act as insurers. The temporary permit was issued for one year. However, there are still two types of insurers in the Russian medical insurance system: 1) medical insurance organizations that are usually non-government commercial entities; and 2) branches of the MMI territorial funds – units of government institutions. In 1997, insurer functions were performed only by insurance companies in 42 Federation member territories, only MMI territorial funds acted as insurers in 23 member territories, and 22 member territories had organizations of both types.

MMI territorial funds should accumulate employers' mandatory medical insurance contributions and payments from local budgets allocated for medical insurance of nonworking citizens. In reality, payments are made in such amounts that are insufficient for funding the MMI programs. In 1997, MMI funds accumulated only 37.5 percent of the costs of a basic MMI program.

It is difficult to make reliable assessments of existence and extent of competition between and among insurers. A general opinion is that there is no such competition. As a result,

expected positive effects of new entities' activities in the health services are not yet clearly pronounced.

The problem of whether non-government insurance should be continued remains an issue for debates. Is competition a necessary condition for efficient insurance activities? Could a positive effect of non-government insurance organizations' work be achieved if there is no competition? A review of these problems and a study of possible solutions is the focus of this research paper.

The second section of the paper gives scenario assessments of the level of financial backing of government guarantees of medical care, and reviews possible ways and means of restoring consistency between government guarantees and their financing.

The third section reviews institutional conditions of efficiency of insurance activities in the MMI system.

The fourth section gives recommendations for the government policy in organization of the MMI system.

2. Financial backing of government guarantees of providing medical care to citizens

2.1. Level of financial backing of government guarantees in 1997-1998

The required spending on providing medical services in amounts sufficient for backing government guarantees came up to 3.68 percent of GDP in 1997, and to 3.85 percent in 1998. These assessments do not include spending on highly specialized medical care, amortization, and procurement of new equipment. Spending on health services from budgets of the RF member territories and from contributions amounted to 3.27 percent in 1997 and to 2.93 percent in 1998.

At the same time, free medical services are actually being replaced by fee-based ones, and a system of under-the-counter payments is developing. A large share of citizens' spending on medical care is taken up by semi-official co-payments for aid which should be provided for free.

In 1998, the Government approved the Program of Government Guarantees of Providing Free Medical Care to Citizens. It does not change a list of free medical services but it intends to transform the structure of providing medical services in favor of less resource-consuming types, e.g., to reduce indoor treatment and shift it to the outpatient services sector.

2.2. Possible options for reaching a balance between government guarantees of providing free medical services to citizens, and financial amounts to ensure that guarantee obligations are carried out.

Two scenarios of possible money collections in 1999 were reviewed. Both were based on the assumption that the rate of employer contributions would remain unchanged (3.6 percent of the payroll). Calculations were made on the basis of nominal GDP in 1998 and an expected decline of real GDP in 1998-1999 by 10 percent.

Scenario 1: optimistic. Compliance of insurance contributions and tax collections to the territorial budgets in 1999 will remain at the 1997 level.

Scenario 2: pessimistic. A decline of insurance contributions in 1999 by 7 percent against 1997, and a decline of tax collections (cash) to the territorial budgets by 25 percent, with the annual inflation rate exceeding 100.

Calculations are given in Table 1.

Table 1

Scenarios of financial backing of government guarantees
of providing medical care to citizens,
in prices as of August 1, 1998, Rub billions *

	Current program		Reduced program **	
	Variant 1	Variant 2	Variant 3	Variant 4
The cost of running a government guarantees program	77.66	77.66	69.90	69.90
Revenues	75.70	57.30	75.70	57.30
Money from budgets of the Federation member territories	53.80	38.00	53.80	38.00
Employers' contributions (at the rate of 3.6 percent)	21.90	19.30	21.90	19.30
Deficit	-1.96	-20.36	5.8	-12.60
as % of revenues	-2.59	-35.53	7.66	-21.99
Deficit per capita, Rub	13.42	139.36	-36.70	86.24

* Variants 1 and 3 correspond to the optimistic scenario, variants 2 and 4 correspond to the pessimistic one.

** Reducing the costs of the government guarantee program: indoor aid on planned hospital treatment is reduced by twofold, from 30 to 15 percent of the total hospital treatment.

Under both scenarios, possible injection of funds in the health care system is too scarce to fulfill in full the government's program of state guarantees. The least painful scenario would be to cut hospital services in case of planned hospitalization (scenarios 3 and 4 in Table 1).

In case unfavorable conditions prevail, it is proposed to cover the deficit through:

Cutting the cost of health care services in the framework of the program of state guarantees in real terms;

Revising government obligations through:

1) introducing co-payments from citizens or
2) creating a universal system of mandatory health care and social insurance and re-distribution of contributions in favor of Mandatory Medical Insurance (MMI) through reducing social insurance.

3. The Role of Insurers in the mandatory medical insurance system

The operation of medical insurance companies in the system of mandatory medical insurance is the object of many attacks. According to the Federal Medical Insurance Fund, not more than a third of insurance companies in the system are operating actively. The rest only transfer financial resources received from the MMI to the medical establishments charging a commission, but do not effect control over the spending, nor control the quality of health care services.

Since 1997, the number insurance companies operating in the MMI has shrink, due to administrative downsizing in 1997 and as a result of the 1998 financial crisis.. In the summer of 1996, the government submitted to the State Duma a draft law excluding non-government insurance funds from the list of MMI facilities. Keeping non-government insurance health care institutions within the MMI network has become especially urgent.

Competition between the users of health care services stimulates more efficient use of resources, but is not a sufficient conditions. With weak competition, or in the absence thereof, with the strong pressure from the state, the buyers may be efficient if:

There are well defined requirements to the structure, volume, quality, cost of health care, that the buyer must ensure;

The government must provide financial conditions for the buyer by ensuring providing economic incentives for effective management (stable financial capitation formulas differentiated by various risks of decease and revised one a year);

Requirements calling for more efficient use of government funds transferred to the buyer;

Low cost of control over compliance with the requirements;

Sizable sanctions for non-compliance with the set requirements and unavoidable enforcement in case violations are detected;

Sufficient awareness and qualifications of the buyer enabling him to take sound decisions to select the most rational health care programs.

The effective terms of operation of insurance organizations and MMI funds in Russia do not comply with the theoretical models for their efficient operation.

There are no uniform government medical and economic standards (protocols) for treatment of ailments which would spell out detailed requirement for the volume, quality and cost of health care services covered by the public finances.

The state requirements calling for more efficient use of funds are declarative in nature and are poorly specified. Budget appropriations are not properly controlled. The main issue is that the MMI programs are inconsistent with available financing. As a result, the funds transferred to insurers do not fully cover health care services provided to the insured. It is not uncommon that the capitation ratios that MMIs use to transfer the funds to health care medical insurance companies are revised several times a year which makes cost saving exercises useless. Therefore, one should not expect that the conditions that insurers operate in will make them operated efficiently.

The fact that the benefits from the operation of the insurance companies re not obvious prompts the authorities to cut them in number and lower their maintenance costs. This is the aim of the accreditation procedures involving the administrative selection of “the most efficient “ organizations which have been introduced in some regions. Such accreditation is an attempt to formally establish social networks and raise their stability by narrowing the list of participants.

At the same time, there are examples of innovation in the operations of Russian insurance companies which set the stage for more efficient use of funds in the MMI system. Such effective institutional initiatives include automated system of accounting for health care services and automated system of pharmaceutical services, introduction of notes [veksels] and plastic cards for automated health care management, introduction of institutions specifying the standards for efficient use of MMI funds, introduction of market-based finance distribution systems, etc.

These examples, however, are more of an exception to the rule. Unless competition is fostered and the government acquires a more prominent role, insurance companies will become redundant intermediaries in the system of public financing of health care. In order to introduce and enforce the standards the government must take action. There is so far, reluctance on the part of the government to take action. On the contrary, regional authorities oust insurance companies from the MMI system.

4. Conclusion. Policy recommendations

The government must ensure consistency between the standards for the volume and structure of health care services envisaged in the state guarantee programs and the financial resources available, and ensure that the government's obligations to finance the programs are in compliance with the key economic objectives in health care. In order to ensure this balance, the state guarantees in medical and social insurance must be revised.

In case the current MMI model involving private insurance is maintained, it will open a strategic opportunity for fostering competition between buyers of public-funded medical insurance and raising its efficiency through the combination of two forces: government pressure and competition. By contrast, exclusion of health case insurance companies from the MMI system, will eliminate such an opportunity.

The further development of MMI requires the following measures:

Elimination of “dual power” in the funding of health care; transformation of MMI funds in all member territories of the RF into treasurers financing MMI programs;

Introduction of comprehensive requirements to the volume and quality of health care services to be detailed for proper cost assessment;

Consistency between the requirements to the volume and structure of health care services and the available financial resources;

Across-the-board coverage of capitation financing by insurance companies from the MMI funds and allowing insurers to retain a margin as the difference between the funds received and health care costs, in compliance with the MMI;

Imposing more stringent requirements to medial insurance companies. This may be achieved though various means by introducing accreditation and expanding license services for the MMI insurers;

Supporting insurance companies in the management of medical services provided to the insured;

Ensuring transparency in the spending of MMI funds by insurance companies and medical organizations.

The implementation of all the above initiatives will incur considerable costs, but if this is not done, the insurance companies will be inefficient, which will call for a simplification of the MMI model. However, it appears that the above requirements may be implemented if there is enough political will on the part of the government.