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Development of Health Care Financial Provision System: Experience in the Russian Federation and in Other Countries

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Abstract:

Health care is a branch of governmental activity, with the main aim to organize and provide accessible medical service and public health care.

A study of economic literature on reforms of health care financial provision in the Russian Federation includes academic papers, analytical reviews, results of health care financial provision experience in the Russian Federation and in other countries.

A conclusion about the inconsistent approaches to institutional foundations of health care facilities, financial provision, peculiarities of formation of sources, composition and mechanism of health care facilities, and justification of ways for further development of health care financial provision in presented.

The diversity of emerging issues concerning Russian health care financial provision, debatableness of their practical solutions, necessity of systematization of successful experiences in many countries requires a more detailed analysis and understanding, which defines the relevance of the topic of the given study.

***Keywords**: Health care, financial provision, financing models, state financing, health insurance, health care single-channel financing.*

***JEL Classification Codes:** I13, I15, I18.*

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1. Introduction

Health of the nation, which is the key area of human activity, defines the quality of citizens' lives and constitutes an element of national security. It is included into the priority list of the Russian Government's socio-economic policy, and the system of health care financing is the primary element of political, economic, social and scientific measures aimed at preserving, strengthening and protecting health of the nation and every individual (Federal Law of the RF No. 329-FZ of 21.11.2011). So, the Executive Order of the President of the Russian Federation "On National Goals and Strategic Objectives of the Russian Federation through to 2024" No. 204 of 07.05.2018 brings the "Health" national project to the forefront and highlights its aims:

- decline in mortality rates of the population in the working age range;
- achieving coverage of all citizens with preventive medical examinations at least once a year;
- optimization of work of health care facilities, providing primary medical care, and provision of its accessibility for population;
- elimination of staff shortages in health care facilities providing primary medical care;
- increase in volume of medical services export, etc.

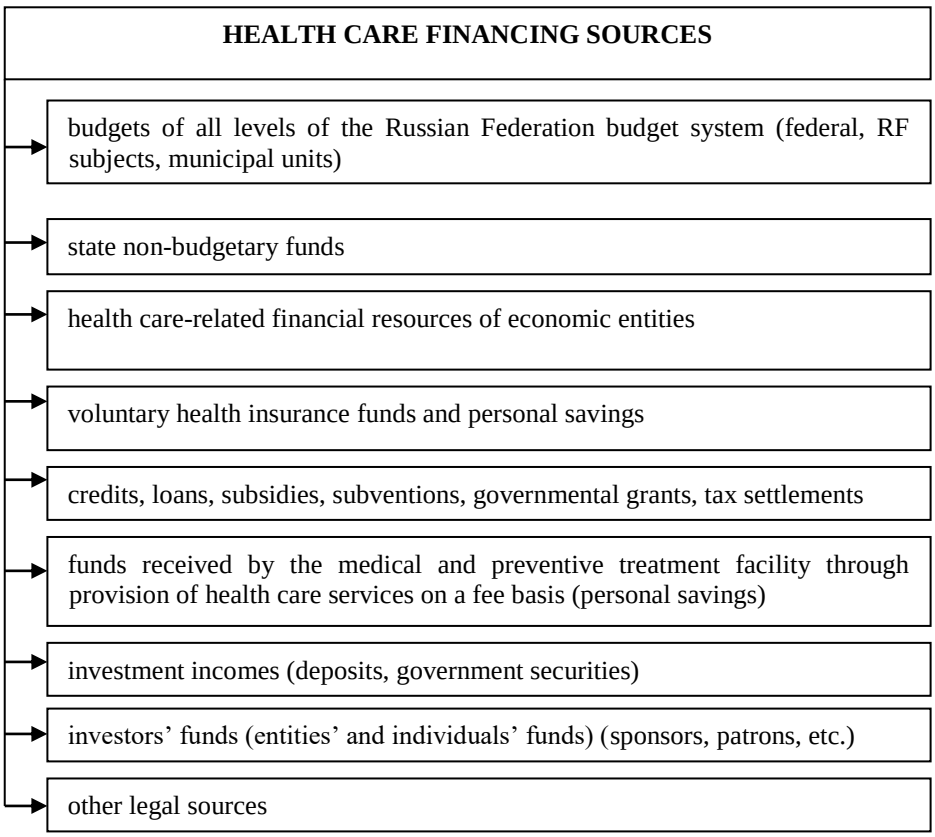
Many countries of the world, including Russia, have been modernizing and reforming health care institutional foundations and the system of health care financial provision. In this regard, multiple issues and questions concerning health care financing in Russia, debatableness of their practical solution, necessity of systematization of experience of financing health care and medical assistance in developed market socially-oriented states require a detailed analysis and a possible adaptation.

2. Foreign experience in building health care financial provision models

The gained experience of health care organization and functioning, the choice of funding sources for health care expenses in some developed market states shows that the interests of at least three parties should be taken into account: state, business, and public (Cristea and Thalassinos, 2016). In this case, the state interest is to have a healthy nation and solid public health; the interest of business is the need for good health of the working part of the population; and the third party, the public, has a strong need for high quality medical services and reliable health care. A market socially-oriented state, like Russia, sees the alignment of the abovementioned interests as a necessary condition required by the social welfare system, which, in its turn, provides the availability of adequate financial resources for health care needs and justified determination of their formation sources.

The global experience of health care financial provision confirms that, in practice, there are various models of financing medical facilities' expenses: state (public), insurance, budget and insurance, private (entrepreneurial) (Lameire, 1999). It should be noted that many scholars conclude that none of the developed market countries has one "pure" healthcare financing model mentioned above. In their opinion, in this case we observe not a financing model, but a dominant source of formation of financial resources for funding current expenses and development of health facilities within Healthcare branch. Nevertheless, both international and Russian practices show a significant number of sources for formation of healthcare financial resources. Figure 1 shows sources of healthcare multicomponent financing.

Figure 1. *Sources of health care multicomponent financing*[5]



It seems important to emphasize the advantages and disadvantages of the current functioning models. For example, the functioning state (public) model of health care financing is characterized by a significant role of the state, which includes: financing the needs of Health care branch from the state budget, provision of free medical care

[5] *Compiled by the Authors.*

to the whole population, control over the quality of medical services and health-care activities and the quality of health care services management. All Nordic countries (Great Britain, Denmark, Ireland, Norway, Finland, Sweden) adopted or preserved this model after World War Two. The Southern European countries (Greece, Spain, Italy, Portugal) joined this group of countries in the 1980s, and Canada did so in the 1970s. Today, this is the dominant model in many developed market countries (Romanova, 2014). In some scholars' point of view, organization and experience of Canadian and European national models of health care financing encouraged preparation of draft of the health care reform in the USA (Andreeva, 2016).

It should be noted that in some countries the state (public) model of health care financing is supplemented by the private sector, covering primarily those spheres of medical care and services which are either not provided or not sufficiently provided within the national branch of Health care. For instance, 10 per cent of expenses on some types of health care are financed through private insurance funds in the UK. The model of state health care in Finland is also supplemented by the private sector: social insurance partially recovers patient's costs, in particular, the doctor's fee is offset by 60% of the settled rate, diagnostic and treatment expenses are offset by 75% of the charge calculated after deducting the set share of private payment, prescribed medications are offset by 50% of the remaining sum. The expenses on transport and the caregiver are partially covered as well (Romanova, 2014).

Historically, the insurance model of health care financing, which is often called the "social insurance system", was first introduced in Germany and later adopted by Switzerland, France, the Netherlands, Austria, etc. It is regulated by state executive bodies, but unlike the state (public) model of health care financing, its financial funds are formed from three sources:

- entrepreneurs' contributions;
- economic entities employees' private funds;
- state subsidies, formed by general and specific-purpose budget revenues.

Thus, the abovementioned counties have their national medical services financed through compulsory contributions made by enterprises (companies and employees) to statutory financial resources funds, which are typically created along professional lines and managed by representatives of the insured. A region of particular interest to us is the insurance model of health care financing adopted in Japan, where health indicators are among the best in the world, and the Health care branch itself is characterized by the following features:

- market regulation of medical services provision (free-market services provision);
- social character of health care financing through universal compulsory medical insurance;
- medical services are usually provided by public medical institutions, although there are private medical institutions as well.

Every citizen of Japan is covered by one or another type of medical insurance. The insurance services are provided in any medical institution of the country; however, the insured person has to pay an average of 10% of treatment cost on his/her own. The country's medical insurance is built upon territorial-production principle, where a patient has a right to choose a doctor, and a doctor is free to choose a method of treatment. Employees' insurance covers 63% of the population in the country; other citizens are insured either as individuals and members of their families or as senior citizens. In Japan, the coverage of medical help for elderly people (aged 70 and older) is carried out through a specialized fund, whose revenues are derived from the national Government (20%), local authorities (10%) and contributions of all insurance companies. Currently, the main sources of covering medical help for senior citizens are employers' funds, whereas the share of the state has significantly decreased.

Thus, mixed additional financing sources of different kinds can be found in the two main financing models. In practice, there are still many differences both inside and between the two main models, i.e. tax-based and insurance-based, and the search for viable and reasonable solutions concerning additional financing sources for health care lies within the state competence of individual Governments. In this context, there are no universally acceptable solutions, which would satisfy the needs of health care financial provision.

An opposite model to the ones of state (public) financing and social insurance is the model of private medicine, which is exemplified by the USA, where initially the private form of health insurance was dominant, and nowadays the system of state-regulated insurance is almost non-existent. Medical services are provided mainly on a fee basis and are financed through the public's own means. The US population is provided with individual and family health insurance in the following areas:

- private insurance, which is well developed in the country. However, there is a condition that no private insurance company is allowed to own over 5% of the national insurance market;
- group insurance, which is provided by employers;
- national (state) medicaid programs carried out at the expense of states and the country for low-income and unemployed citizens, as well as Medicaid for people of retirement age over 65 (Vovchenko, 2005).

Currently, from 80% to 90% of the US population are covered by one or several types of insurance in cases of disease or traumas. However, over 30 mln of Americans under 65 have no health insurance, and 20 mln more have limited insurance. The problem of equal access to medical care and its provision in the required amount and quality is evident (Vovchenko, 2016).

3. Health care financing and development in the Russian Federation

Since the late 1980s, Russian health care has gone through a series of continuous reforms, when special attention has been paid to the issues of economic modernization of the branch, which initially was justified by establishing a new economic mechanism and its development in branches of the social sector, and later by establishment and implementation of compulsory medical insurance. It was a period of large-scale changes in the country, characterized not only by gradual reforming of the national model of economy, but solution of a set of problems concerning national health care, including its low socio-economic efficiency and inadequacy of its financial provision, which became the driving force behind modernization of the Health care branch (Andreeva, 2013). Russian health care system has been undergoing the process of reforms for almost a quarter of a century. As a result of these reforms, since 1993 Health care branch of the Russian Federation has been functioning in the framework of budget and insurance model, which has the following basic financial parameters:

- formation of financial sources through the combination of budgetary approaches and insurance principles to create funds of health care financial resources;
- contractual relationships establishing the rules of financing medical institutions by insurers;
- payments for medical services based on different options for medical institutions' services accounting;
- pricing of medical services in accordance with rates established by the system of compulsory medical insurance, a limited set of services determining the costs of health care;
- planning of medical care amounts on the basis of established financial ratios.

The Authors come to the conclusion that the budget and insurance model in question is more advanced as compared to the previous state system of health care financing, because during the tough 1990s the budget and insurance model helped ensure the foundations of Russian health care and provide a smooth transition to the system of public health care based on the principles of basic medical services provision under the predetermined economic efficiency of Health care branch as defined against costs criteria.

However, this model failed to find a solution to the main issue connected with achieving the adequate level of Health care branch financial provision. Besides, financial flaws of compulsory medical insurance and budget funds are still intertwined, accounting is non-transparent, state financial control over the use of funds is low efficient. A serious drawback is the lack of integrity of the system of economic incentives for medical services providers, which leads to dysharmonization of their economic interests and loss of clinical continuity in their work. The reasons for the abovementioned drawbacks stem from incompleteness of the functioning organizational models of compulsory medical insurance system, imbalance of administrative and market levers for management of its financial resources.

Further improvement of financing mechanism of medical help and public health care based on results demanded transition to the primarily single-channeled financing of medical institutions' activities, which also supposed that the majority of funds would come from the compulsory medical insurance system, and payment for medical care would be carried out according to results based on comprehensive performance indicators (Andreeva, 2015). In this context, the initiators of the proposal for implementation of the single-channel financing enumerated its following advantages:

- firstly, financial provision for the whole scope of medical help and public health care is realized fully with regard to real expenses (concerning finished cases), which involves change of structure and quality of the medical services provided;
- secondly, the principle of equal access is achieved through introduction of unified standards and per capita financing of outpatient care;
- thirdly, effectiveness of financial resources use and efficiency of budget expenditures are increased (Otrishko, 2015).

The experts' point of view was that the primarily single-channeled financing of medical institutions would allow to:

- optimize organizational foundations of health care delivery and develop its priorities;
- improve outpatient care, general practitioners' health care delivery;
- introduce payments for medical services on the principle of finished medical cases, etc.

Implementation of the single-channeled financing of medical institutions required solution for a number of key issues:

- transition to the primarily single-channeled financing of medical care through the compulsory medical insurance system since 2013;
- organization of practical provision of medical care in accordance with medical standards;
- introduction of a unified standard of subsidies for the budgets of territorial compulsory medical insurance funds for realization of the territorial program of compulsory medical insurance;
- transition to a unified insurance premium rate for the compulsory medical insurance of unemployed citizens, etc.

It should be noted that a pilot project was realized in 19 subjects of the Russian Federation in 2007-2008. Its main aim was to transfer health care institutions of those regions to the primarily single-channeled financing through the system of compulsory medical insurance. 30% of all medical and preventive treatment facilities participated in the project. The ongoing pilot project was supposed to work through the mechanism of consolidation of budgetary funds of all levels of the

compulsory medical insurance system, which was achieved as a result, on average; the relation of compulsory medical insurance funds to budgetary funds was 58%/42% (Remedium, 2018).

The authors believe that despite the abovementioned facts concerning single-channeled health care financing and the results achieved during the pilot project, the "pure" form of the model in question has not yet been realized. It is enough to recall that under current conditions the Russian Health care branch has medical help and health-care activities funded simultaneously from budgets at all levels of the budgetary system, financial resources of insurance medicine (compulsory and voluntary); considerable revenue is also gained from the public for provision of various kinds of paid medical services.

The authors' approach to the notion of the "single-channeled health care financing" and its content suggests an opposite to the current multiple financing sources disengaged in respect of formation and use of financial resources. The authors propose an introduction of financing with all legitimate health care financial resources coming through one single channel, regulated by the state (incoming financial resources), and used for the full financial coverage of all kinds of expenses of medical institutions (outgoing financial resources), which would ensure a sufficient level of concentration and control over financial resources of the Health care branch, unity of their volume, quality and accessibility of medical help at the level of the whole branch and every medical institution.

This approach seems to present a possibility to create a new management technique for financial flows channeled from different financial sources for health care, as well as coverage of medical institutions with financial resources through the single-channeled financing in accordance with business plans and state orders.

4. Results

In the past two decades, all Russian economy, social sphere, and its primary branch, Health care, have been involved into complex and diversified reform processes. The results of these reforms are:

- creation of insurance medicine (compulsory and voluntary forms);
- formation of the budget and insurance model of medical institutions' financing;
- appearance of private medical institutions providing paid medical care, which conditioned the beginning of formation of competitive medical services market.

Besides, a lot has been done to achieve an optimal structure of distribution of responsibilities and budgetary financing of state and municipal medical institutions among authorities (the state budget and compulsory medical insurance budgets) at different levels.

However, despite all these and other undertaken organizational, market and financial innovations in health care, socio-oriented market economy, which is being formed in Russia, places new demands on Health care branch. They are growth of financial resources for maintenance and development of medical institutions providing high quality and accessible medical care, and growth of efficiency and effectiveness of the use of financial resources for these purposes. The difficulty of meeting these requirements is accentuated by immaturity of the modern technique of forming financial resources for medical institutions, a big amount of financing sources disengaged in respect of financial resources management, absence of state regulation of paid medical services development, and therefore state financial control over financial flows.

Research demonstrates that an instantaneous transition to the primarily single-channel health care financing through compulsory medical insurance funds cannot currently solve the problem of financial resources deficit in the system of state and municipal health care institutions, generally provide adequate financial provision for the needs of the health care branch.

Like other models, single-channel health care financing through compulsory medical insurance funds does not suggest a single source for financial resource formation. In order to provide an adequate level of financing for the needs of medical institutions it is necessary to maximize the use and combine all possible sources of financial resources formation, providing efficient results-driven use of the mobilized resources. As for organizational basis of the method of single-channel health care financing through compulsory medical insurance funds, "the Single treasury account" of the federal budget of the Russian Treasury institute is highly recommended for this purpose. It will provide a real possibility to exercise state financial control over financial flows, as well as a possibility of efficient management of temporarily available health care funds.

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