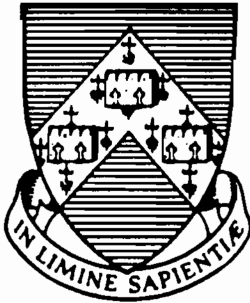

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Health Care Reform in Russia

by
O. P. Schepin, V. Yu Semenov
and Igor Sheiman

DISCUSSION PAPER 102

HEALTH CARE REFORM IN RUSSIA

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December 1992

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Acknowledgements

Thanks are expressed to Sue Hennessy for her work in editing these papers, the contents of which are the sole responsibility of the authors.

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Abstract

The break-up of the former Soviet Union has created a greater realisation of the health and health care deficiencies of what are now independent states and the need for reform. The purpose of these two papers is to describe these deficiencies and set the scene for the establishment of some form of national health insurance in Russia and the other states in the near future.

The level of infant mortality across the former Soviet Union in 1990 was 21.8 per thousand. This average disguised wide regional variations, from 32 to 55 per thousand in the rural areas of Middle Asia to 11 to 18 per thousand in the more economically developed areas of the Baltic Republics, Russia, Byelorussia and the Ukraine. Average life expectancy in 1989 was 69.5 years, 64.6 years for men and 74 years for women, and there were significant regional variations. The major cause of death is cardio-vascular disease and there is evidence not only of late diagnosis of disease but also of a large proportion of chronic diseases being undetected.

During the 1980s the health service expanded: more doctors were employed, the hospital bed stock increased and outpatient clinic capacity rose. The rate of hospitalisation is high and the utilisation of facilities is poor eg average length of stay exceeds 15 days.

Any reforms will need to change the funding of health care and improve the efficiency of the delivery system. Thus reformers are discussing the decentralisation of management functions away from the centre to the regions, improvements in management training, and improved coordination between the primary and secondary parts of the health care system. Experiments

involving decentralising budgets being related to activity and outcome goals, have been carried out in various parts of Russia.

In Russia, legislation has been passed to introduce health insurance from January 1st, 1993. The fine detail of this scheme, even at this late stage, is still undecided. Furthermore the infrastructure to collect and distribute funds has not been created. Further legislation has been introduced which separates consumers, purchasers and providers.

The health and health care problems in Russia and other parts of the former Soviet Union are great and the ambitions for reform are well articulated at the level of principle. However the translation of these principles into practice, when the economy is facing high levels of inflation and decreasing output, and when the administrative structures to facilitate the finance and management of the proposed decentralised system are absent, is a mammoth task. These papers demonstrate that Russian academics and policy makers recognise these problems and are rising to the challenge of resolving them.

Alan Maynard

THE SOVIET HEALTH SERVICE SYSTEM

REFORM

BY

O P SCHEPIN AND V YU SEMENOV

INTRODUCTION

The former USSR comprised one-sixth of the world's land surface and contained many national groups. It included more than 100 large and small nationalities, which were grouped into 15 Soviet republics, 20 autonomous republics, eight autonomous districts and 123 districts. The population, at 1st January 1990, stood at 288.6 million, of whom 66 per cent lived in cities and towns and 34 per cent in rural areas. A majority of the population, 53.5 per cent, were female.

During the last 20 years there has been a fall in the population growth rate, which on average was 0.6 per cent. The average growth has been due to rises in the Middle Asia Republics (2-3 per cent per year) and in the Caucasus Republics, Kazakhstan and Moldova (1-1.5 per cent per year). In other areas, Russia, the Baltic Republics, Ukraine and Byelorussia, population growth was zero.

Statistical data for the health of the population - high mortality and infant mortality rates, high rates of invalidity, low life expectancy, increase in chronic morbidity and a poor public health service - and dissatisfaction of patients with health care provision highlighted the need for reform of the service. In addition, the aims and objectives of the World Health Organisation "Health for All" programme called for the development of long term strategies for health promotion and health maintenance.

The basic principles of the health service system were laid down 70 years ago in very different political, economic and social circumstances from those of the present day. The

system is in need of deep and radical changes, which must deal with structural, functional and financial questions, issues such as material and technical resources, pharmaceutical use and development, staff training and management.

1 DEMOGRAPHIC TRENDS AND HEALTH STATUS

The health of the nation is determined mainly by the socio-economic level of a country's development, by ecological conditions, by nutritional standards and by the levels of educational provision, housing, welfare benefits and leisure spending.

An important indicator in this respect is the birth rate, which was 17.6 per thousand in 1989. The decline in the birthrate, from 18.3 per thousand in 1980 and 20 per thousand in 1986, was noted in all regions of the USSR. However, there is significant regional variation. The highest birth rate is in the Middle Asia region (30-39 per thousand), while in the Caucasus region, Moldova and Kazakhstan it is 18-26 per thousand and the lowest rate is found in the most highly developed regions of the country, the Baltic republics, Ukraine, Russia and Byelorussia where it is 13-15 per thousand.

It is expected that there will be a greater decrease in the birth rate in Middle Asia than will apply to the rest of the country, and a more modest decrease in Caucasus, Moldova and Kazakhstan, with the rate stabilising in the Baltic Republics, Russia, Ukraine and Byelorussia. Decreased fertility rates for younger women are likely to be offset by increased rates for older women.

The age composition of the population shows signs of an ageing population and it is predicted that by 2000 16 per cent of the population will be aged 60 years or over; in the economically developed regions this figure will be 19 per cent. There will be an increase in the numbers of old people living alone, particularly in rural areas.

Changes in the birth rate are closely linked to changes in infant mortality rates. There was a decrease in infant mortality until 1971, followed by fluctuations in the rate. However, since 1985 infant mortality rates have been decreasing, and this is true for the whole country.

The level of infant mortality was 21.8 per thousand in 1990 but there were significant regional differences. The rate was 32-55 per thousand in Middle Asia (rural area), 19-26 per thousand in Caucasus, Moldova and Kazakhstan (partially developed areas) and 11-18 per thousand in the Baltic Republics, Russia, Byelorussia and Ukraine (economically developed areas).

International comparisons of infant mortality rates must recognise the regional differences within the USSR as comparisons with the average figure for the USSR are not valid. The rate for the six economically developed republics (11-18 per thousand) is similar to the rate for East European countries (Bulgaria, Hungary, Poland, Romania and Czechoslovakia) where infant mortality is 13-23 per thousand. There is greater regional differentiation within the USSR itself, than between the six economically developed republics and Western European countries (6.8-10.3 per thousand in 1986) and North European countries (6-9.5 per thousand in 1986).

The infant mortality figures for Middle Asia, Caucasus and other less developed territories compare favourably with other countries with a similar level of economic development, for example Turkey (73 per thousand), Mongolia (66 per thousand), Iran (50 per thousand) and China (31 per thousand).

The infant mortality rate is lower in more developed regions. It is, therefore, predicted that the greatest decrease in infant mortality will occur in Middle Asia (the least developed area), a modest decrease will be seen in Caucasus, Kazakhstan and Moldova, and the lowest decrease will be in the economically developed republics.

The figures for mortality and life expectancy are very poor. Average life expectancy for children born in 1989 was 69.5 years, 64.6 years for men and 74 years for women.

The crude mortality rate increased between 1960 and 1980, rising from 7.3 per thousand in 1965 to 9.3 per thousand in 1970 and 10.3 per thousand in 1980. Thereafter it remained almost stable, at 10.6 per thousand in 1985, 9.9 per thousand in 1987, 10.1 per thousand in 1988 and 10 per thousand in 1989. The highest levels of mortality were seen in the Baltic republics, Russia, Ukraine and Byelorussia, and the figure for 1989 was the same as that for 1979. It is anticipated that the Middle Asia republics, which have a relatively low mortality rate, will see an increase in the near future.

A breakdown of the causes of death show that a majority, 56.1 per cent, are due to cardiovascular diseases. Other causes of death are neoplasms (oncology) 16.2 per cent,

traumas and poisonings 8.9 per cent, diseases of the lung and bronchus 8 per cent and infectious diseases 2.1 per cent.

There are large regional variations in pathology. The highest level of pathology is found in the partially developed territories (70-80 per cent) and the lowest level in Middle Asia (34-49 per cent), where diseases of the lung and bronchus are the second most frequent cause of death, followed by infectious diseases.

A complex evaluation of the health status of different groups of the population, by age, shows that there is a higher rate of chronic illness for older people. In 1989 the rate was 21.7 per cent for adults, 14.6 per cent for teenagers and 9.3 per cent for children. It is believed that a large proportion of chronic diseases remain undetected.

More than a billion working days were lost to the economy due to illness and caring for sick relations (mainly children) in 1990; the figure was the same in 1985. This is equivalent to 4 million workers, or 3 per cent of total manpower, being absent from work. Morbidity with temporary disability increased between 1986-90 in most of the republics, especially in Moldova, Byelorussia and Lithuania, where the increase was 10-19 per cent compared with a national average of 0.7 per cent.

There were more than 164 million cases of disease registered in the country's health institutions in 1990. Of these, 84 million (or 294 per 1000 inhabitants) were diseases of the lungs and bronchus, 19 million (64 per 1000) were traumas and poisoning, 12 million (42 per

1000) were neurological diseases, 9 million (32 per 1000) were skin diseases, 8 million (27 per 1000) were digestive diseases and 6 million (21 per 1000) were musculo-skeletal diseases.

A quarter of people with endocrinological diseases (more than one million people) have diabetes. The figure varies from region to region, ranging from 127-147 per 100,000 inhabitants in Estonia, Armenia and Ukraine to 44-46 per 100,000 in Tadjikistan and Uzbekistan.

The oncological morbidity rate is very high, especially in Ukraine, Kazakhstan and Estonia, where it is 6-18 per cent higher than the national average. The proportion of patients receiving a late diagnosis is increasing, from 19 per cent in 1980 to 21 per cent in 1987 and 27 per cent in 1990. The figure for Uzbekistan, Estonia and Turkmenia is 26-33 per cent. The rate of patients who died during the first year after diagnosis was very high in these republics and in Kirgizia: 67-75 per cent, compared with an average of 55 per cent. The reasons for this are shortages of equipment in hospitals and clinics and poor training and performance of doctors.

Death from infectious diseases is increasing in some areas of the country. Death due to digestive infections increased by 1.6 times between 1985 and 1990 in Latvia and doubled in Kirgizia and Tadjikistan. Viral hepatitis morbidity increased in Kazakhstan, Azerbayjan and Latvia by 1.3 times, in Byelorussia by 1.5 times and in Armenia by 1.6 times.

The increase in infectious diseases is due to inadequate standards of water supply and

treatment, pollution and the violation of sanitary and technological rules during food preparation, storage and transportation.

Hospital infections form a special problem. Records show that there were more than 30,000 cases of septical infection of infants in hospital, 12,000 mothers and 27,000 cases of post-operative infection.

The health status of the population is due in large part to poor standards of nutrition, particularly the quality of food and problems of hygiene in the food preparation industry. Other significant influences on health have been population migration, with migrants having higher levels of physical disorders and traumas, environmental pollution and low safety standards at work. There is little popular interest in self-help health promotion and maintenance.

Worsening trends in health standards have for many years been blamed on the inefficiency of the health service, but it is now evident that these are features of the total crisis in the country.

2 PRESENT SITUATION IN THE HEALTH SERVICE

2.1 Health Care Services

As the first section of this paper demonstrated, the health status of the population of the USSR has been worsening. The health service has been unable to reduce the problems of

public health and this has led to a search for new solutions.

The simplest solution was to increase the volume of heath services provided for the population. Indeed there have been positive developments in health care provision in recent years. As well as an increase in the total number of doctors (1.2 million) there has been an increase in doctors in primary care. In the 1980s the number of utschastok[1] doctors increased by 14 per cent, occupational doctors by 11 per cent, gynaecologists by 13.5 per cent and stomatologists by 16 per cent. In total the number of medical staff in hospitals rose by 2 per cent between 1985 and 1990, while in polyclinics[2] it rose by 10 per cent. The number of nurses increased by 12 per cent. There is still a shortage of para-medical staff in hospitals and clinics. In addition there is regional disparity in the numbers of doctors per 1000 inhabitants, the figure being twice as high in the Baltic Republics and Georgia as it is for the Middle Asia republics.

The capacity of outpatient clinics increased by 16.8 per cent during the 1980s. However, the number of independent polyclinics decreased during the previous 15 years by more than 50 per cent in towns and cities.

More than half of new outpatient clinics in urban areas and virtually all of those in rural areas are set up in adapted buildings. The rate of building new centres has decreased to 20 per cent

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1 Utschastok doctors work in outpatient services. They are responsible for about 1700 people and are the patient's first point of contact with the health system. There are separate utschastok doctors for adults and for children under 15.

2 Polyclinics are outpatient medical centres where patients are treated by utschastok doctors and specialists. They can also have diagnostic tests and x-rays performed and receive physiotherapy etc.

and the average time for construction is three to eight years.

In 1986-1990 there were 336,800 new beds, which is 6 per cent more than during the previous five years. The capacity of new outpatient clinics was 945,200 visits per day, 33 per cent more than in the previous five year period. In total there were more than 43,000 outpatient clinics handling 5.5 million visits per day, 24,000 hospitals with 4 million beds and about 30,000 maternity centres in the country.

There have been some positive developments in primary care provision: local health centres, based in the community and organised on the principle of "family doctors"; diagnostic centres; polyclinics; well-person clinics and specialised polyclinics at research institutions.

Despite these improvements in primary care, hospital services account for the majority of health services overall. Expenditure on hospital services is 60 per cent of total health expenditure, and 40 per cent of health service personnel work in hospitals. During the last 20 years, expenditure per bed per year increased by 50 per cent and capital investments per each new bed by 90 per cent. Bed occupancy was 310 days in 1988 and the average length of stay was 15.75 days. The rate of hospitalisation was very high: 24.7 per 100 inhabitants in 1988. Increased expenditure on hospital services has a detrimental effect on expenditure on primary care and developments of public health.

2.2 Health Service Finance

Health services are financed by the state budget and health institutions receive money from government departments, such as the Ministry of Health and local and regional health authorities.

The financing of health institutions is based on an annual budget covering 12 main items of expenditure including salaries, drugs, equipment, food, maintenance and investment. Calculations are made according to different parameters for each item; for example the salary fund is based on an average staff salary, drugs and food are assessed per one patient per day. The items included in the budget are determined by the Ministry of Finance and the schedule is applied to all health institutions.

In the last 25 years, expenditure from the state budget and other sources increased by 5.4 times and reached 36 billion roubles in 1990, an annual average of 125 roubles per capita. As a proportion of national product, health expenditure remained stable at about 4 per cent (4.7 per cent in 1989). Between 1960 and 1986 health service expenditure declined as a share of the state budget, from 6.5 per cent in 1960 to 4.1 per cent in 1986. Since then it has increased following changes in health policy and in 1989 reached 5.1 per cent. The increase is linked to rises in staff salaries by an average of 30 per cent since 1986. In addition, 5.4 billion roubles were allocated for health service investment in 1988 and the allowances for drugs and some medical equipment were increased by 50-100 per cent in 1991.

As a result of these additional expenditures, total health service expenditure increased by 13.5 billion roubles (more than 50 per cent) between 1985 and 1990. Salaries accounted for 50 per cent of total expenditure, equipment 5.6 per cent, patients' food 7.6 per cent, drugs 9.5 per cent and investment and maintenance 16 per cent.

The financing of health services depended on negotiations between the Ministry of Health and the Ministry of Finance, and between health service providers and local government authorities.

These negotiations have resulted in health care receiving a greater share of the state budget since 1985 and health expenditure has increased by 50 per cent in absolute terms. However the effects of inflation are such that there has been decline in real terms. The system of health service financing is in need of reform and a trial scheme has been set up in Leningrad, Kemerovo and Kuibyshev to develop a new system.

2.3 Key Problems in the Health Service

A number of key problems confront the Soviet health service: the quality of medical care; the development of primary health care in accordance with the Alma-Ata Declaration (1978); and the development of health promotion and preventive work.

In order to improve health service delivery it will be necessary to reorganise the health service on a regional level, to decentralise managerial functions, to encourage co-ordination

between different branches of the service, to increase the efficient use of resources and to develop the professional abilities of medical and managerial staff.

In order to address these issues, three regions of the Russian Federation were selected as pilot areas to implement and evaluate proposed reforms to the Soviet health service. The results of this trial are outlined in the following section.

3 MAIN DIRECTIONS OF THE REFORMS

The main feature of health management 'perestroika' is the reform of the system of financing the health service. It is intended that such changes will increase the role of staff in service management and encourage a more efficient management system at all levels of the service. Attempts to avoid reform by making available additional resources fail to recognise the impact of the new social, economic and political climate. The main weaknesses of the health service are structural and significant organisational changes are required. Firstly, the replacement of centralised management by a strategic and systematic decentralised approach, and, secondly, extending the principle of decentralisation to planning, investment and resource allocation.

In order to evaluate the proposed reforms a pilot scheme was introduced in three territories of the Russian Federation (Leningrad, Kemerovo and Kuibyshev regions) with the aim of improving the planning, financing and management of health services. This was to be accomplished by the more efficient use of resources, improved quality of medical care, managerial decentralisation and increasing the rights of health service administrators and staff.

A new system of health service finance was envisaged, introducing significant changes:

i) amending the budgetary system of financing health systems by replacing the existing method of financing according to items of expenditure with a system which relates finance to productivity and outcomes;

ii) introducing elements of private health care into the system; firstly by allowing enterprises to purchase health services for their employees from state run health institutions, and secondly by allowing individuals to purchase private health care;

iii) linking the size of the salary fund and social development fund with levels and outcomes of activity;

iv) buying-in from private providers via leasing arrangements, co-operative development and purchasing services from the private sector.

3.1 Management

A new unit was introduced into the health service, the Territorial Health Association (THA), which was given overall responsibility for health care in the region. The THA is an umbrella association for territorial health institutions and is responsible for the provision of health care to its population and for allocating the budget it receives from the District Health Authority.

As well as hospitals, the THA includes community health services (polyclinics for adults and children, stomatological polyclinics, and maternity centres) and ambulance services. The community health services undertake a pivotal role in providing health care for their community. Financed by the THA according to the health profile of their area, they purchase services from hospitals, specialist clinics, ambulance services and other health organisations.

Although health institutions may be formally independent of the THA, in practice the THA has powers to centralise or re-allocate their functions, resources and staff.

One primary responsibility of the THA is to meet its population's health care needs. To this end it has a duty to provide primary health care, outpatient services, accident and emergency services, maternity care and inpatient care for both acute and long-stay patients. The THA is free to decide how treatment should be provided.

The territorial or district health authority is responsible for co-ordinating managerial activity. The Ministry of Health should not take part in the day-to-day management of the health service. Its role is to develop and implement policy, organise manpower development and training, and encourage co-operation between different branches of the health service.

3.2 Planning

The system being introduced in Leningrad, Kemerovo and Kuibyshev has introduced outcome and productivity targets for THAs and other health institutions.

Health authorities determine targets and objectives for the THA and health institutions including such factors as the number of patients treated and types of services provided. These objectives are long-term and intended to facilitate the planning and development of the health service.

Health institutions are financed according to the volume of work undertaken. The price paid for each service is determined by health authorities each year, and the agreed price may only be changed during the year if the price of food and drugs etc changes.

3.3 Finance

The reforms introduced significant changes in the finance of the health service with hospitals, clinics and other health institutions being funded according to the quality and quantity of their activity. A key introduction was a new system of finances based on tariffs (or prices) which would reflect the volume of work. Thus, hospitals would receive the tariff for each patient treatment (depending on the diagnosis), outpatient and primary care institutions would be paid for each inhabitant of their area according to local population health status profile, and the ambulance service would be paid the tariff for each call at a rate depending on the complexity of the case. The sanitation stations would be financed on the basis of population size and the sanitary and epidemic situation in their region.

The main sources of funding are the state budget, enterprises' payments for additional medical services for employees, and private payments made by individuals.

District health authorities established a "centralised fund" from their budgets to pay for supra-district services: for example, reimbursement for medical services provided to patients from another district; research centres; specialist institutions; postgraduate students.

The THA is financed by the health authority according to the size of the district's population and the THA is responsible for allocating funds to all health institutions within its district

according to the criteria outlined above. The level of tariffs to be paid is set by the health authorities.

Any resources remaining after the health institutions have been paid form a profit for the THA. Part of this profit is returned to the health authority according to laid down guidelines. The remainder is at the disposal of the THA and surplus resources may be carried over to the following year.

3.4 Development Funds

Part of the THA's profit is used to finance three funds; salary fund, industrial and social development fund and financial incentives fund.

The salary fund is based on a proportion of total health service expenditure which is determined by the health authorities. The fund is used to pay salaries and it is intended that salaries should be performance related. The number, structure and quality of staff is determined by the THA within the limits of a fixed budget.

The industrial and social development fund has two functions: firstly, to purchase equipment and machinery and to finance technical reconstruction; and, secondly, for social support and development of personnel. The THA can use part of the financial incentives fund for industrial and social development aims, but not vice versa.

The financial incentives funds is used for bonuses and other forms of incentives to improve the quality and quantity of work.

3.5 Impact of the Reforms

The experimental introduction of the reforms has produced positive results, in particular the transfer of responsibility to health institutions' adminstration and staff in determining the use of resources, staff and equipment and in introducing changes to increase efficiency.

However, the new financial arrangements bring the risk of a conflict of interests between consumers and the health institutions. Attempts to increase the THA's profits may have a detrimental affect on medical services to patients: in order to avoid expenses, doctors may choose methods of treatment which are cheaper and less effective; patients may be refused consultations, inpatient care etc.

The right of polyclinic doctors to be fundholders has resulted in problems between outpatient clinics and hospitals over the treatment of patients. It is suggested that fundholder doctors may view patients as a source of income and have less interest in them as patients.

4 HEALTH INSURANCE SCHEME

The health reforms experiment demonstrated the problems of combining the provider and purchaser functions. There is a need for a mediator between the health institutions and the patients. During the last two years work has been underway to introduce a health insurance scheme and bills were drawn up to cover the whole of the USSR and for some individual republics. At the time of writing, health insurance laws have only been enacted in Russia and Estonia. In the Russian Federation preliminary legislation has been introduced which will form the basis of the transition to a system of health insurance.

The law will introduce voluntary insurance from 1st October 1991 and compulsory insurance from 1st January 1993. The intervening period will act as a pilot scheme prior to full implementation.

The health insurance act provides for compulsory health insurance for all citizens. The scheme will guarantee a set level and quality of medical care and pharmaceutical services. Additional medical and other services will be provided by voluntary health insurance schemes or by personal expenditure. A very basic compulsory scheme will be established by the government of the republic; each region and territory will be responsible for developing their own programme to complement the basic conditions laid down by the republic.

It is not yet clear what the final programme of the Russian Federation will include. However, it is evident that the transition to a health insurance system will entail a reduction in the accessibility of medical care, since at present everyone has the right to receive medical care

free of charge in any health institution. In practice there are at present some limitations on the availability of health care, for example a referral from a doctor is required for treatment at highly specialised clinics, waiting lists delay access and a black market exists in some cases. Nevertheless it is every citizen's right to have high quality specialist medical care and this will be limited by the introduction of a compulsory health insurance scheme.

It is anticipated that insurance for those who are not economically active (children, pensioners, the unemployed etc) will be paid for by local authorities. Employers will pay the premiums of their employees. The costs of health insurance will be included in the price of production. People will not pay premiums out of their own pockets. The basic rate of insurance premiums will be determined by the government of the republic at a set rate for the non-working population and as a proportion of wages for those in work. Voluntary health insurance will be funded by personal incomes and/or profits.

Under the health insurance system, everyone will have the right to choose a health insurance company, health institution or doctor. This will increase the rights of patients and accessibility of medical care. A health insurance company has no right to refuse to provide health insurance. Once the patient has arranged health insurance he or she can receive medical care only from those institutions with which the company has contracts. This will limit the rights of patients, but will increase competition amongst the health insurance companies.

According to the act, all citizens of the Russian Federation will have the right to receive a reimbursement of part of their voluntary insurance premium if they are in good health during

the year. This will encourage people to maintain their health. However, it may lead to financial problems for insurance companies who will simultaneously have to reimburse those people who have not required medical care during the year as well as paying the expenses of those who have needed treatment. Such a situation may lead to increases in premium levels.

It is intended that a decrease in sickness rates will be encouraged by a clause in the act which allows for premiums to be reduced for companies where the sickness rate is stable or decreases for three or more years. This provision aims to encourage the development of improved health and safety standards at work.

The role of health authorities will be significantly reduced. They will continue to finance medical training and advanced education, scientific research, technical developments, high cost medical care and epidemic illnesses. In addition health authorities will subsidise some areas which lack resources with the aim of ensuring equal levels of medical care for the different areas of the region.

Institutions providing medical care will be financed according to a set of tariffs agreed between the health insurance companies, local authorities and professional medical associations. However, the different methodological approaches to price determination may lead to conflicts and make it difficult to reach agreements. Besides there are virtually no professional medical associations in the country and their absence in 1993 will make it difficult to implement the act.

CONCLUSION

The present system of Soviet health care does not meet the demands of the consumers or the providers of medical care. Although extensive development of the system has led to high ratios of doctors and hospital beds in proportion to population, resources are used inefficiently and irrationally.

The reform experiment introduced strategies to regulate the health system, to increase efficiency of health institutions and performance-related pay for medical staff. At the same time, giving polyclinic doctors responsibility for purchasing medical services for their patients has led to opportunistic relations between primary and secondary health care services, and has resulted in patients being denied specialist consultations and treatment which they require.

In a further development, a law was adopted in Russia in June 1991 "About health insurance of citizens of RSFSR", which introduced a separation between consumers, providers and purchasers of medical care. Its aim was to encourage improved quality of care and efficiency of resource utilisation.

It will not be possible for this act to be implemented from 1st January 1993, because medical workers will not be ready to work in the structure of the health insurance scheme. A campaign of information and staff training will be required before the health insurance scheme can be put into practice.

The implementation of the act should begin with the introduction of voluntary insurance schemes and compulsory insurance should be introduced experimentally in some regions of the republic.

During the transition period it is important that health authorities regulate the volume and quality of medical care provided under the voluntary insurance schemes. Since health institutions receive higher payments from insurance companies than they do from health authorities, they may give preferential treatment to patients who are covered by voluntary insurance. The health authorities must monitor this situation to ensure that equality in access to and quality of medical care is maintained.

It will be necessary to undertake research in due course to evaluate the effectiveness of both compulsory and voluntary health insurance programmes.

STATE TAX-FINANCED OR HEALTH INSURANCE MODEL?

A DIFFICULT CHOICE TO BE MADE IN RUSSIA

by

Igor Sheiman

STATE TAX-FINANCED OR HEALTH INSURANCE MODEL?

A DIFFICULT CHOICE TO BE MADE IN RUSSIA

The Medical Insurance Act which was passed by the Supreme Soviet of the Russian Federation in June 1991 has become a starting point for the reform of the health care system. The main object of the reform is a transformation from state tax-financed provision of health care to a mixed budget-insurance system. However, the future of the reform proposals is uncertain, not only because of economic problems and political instability but also because the Act does not include sufficient details regarding the implementation of the reforms and the transition to the new model. Discussion of these issues is now underway.

The aim of this paper is to look at the question of health care reform in Russia with a view to comparing the state tax-financed and the health insurance models. The first part of the paper addresses the problem of the need for reform. It presents the main characteristics of finance and organisation of health care in Russia and compares these with the NHS. Secondly, an attempt is made to compare the state tax-financed model with both social and private health insurance models. Thirdly, the problems of transition to the new model are discussed. Finally, a possible approach to building up a regional health insurance scheme is offered. In the course of the discussion I have tried to compare our future reform with the current reform of the NHS.

The main focus of this paper concerns the Act and further regulations which are being worked out by the Russian Federation Ministry of Health. Some points go beyond the Act and reflect the approach adopted by the author and the group of health officials of Kemerovo Region in

Siberia who are responsible for the first experiment with a regional insurance scheme.

1 The Main Characteristics of the Health Sector in Russia

Health care in Russia is a state tax-financed comprehensive system which provides free medical care to all citizens. The overwhelming majority of medical facilities are state-owned and directly governed by the central, regional and district health authorities. The system is based on a fixed budget provided from general revenues. The 'fixed budget' scheme of finance and budgeting makes it possible to control the costs of medical care and rigid vertical administration of the system ensures regional planning of resources. These are the positive characteristics of the system, however some of them are advantageous only in theory but not in practice.

At first sight the system is similar to the NHS and its similarity is stressed by the opponents of the reforms in Russia, who appeal to the high international reputation of the NHS, and argue that both systems can serve as models for the rest of the world. However they overlook the fact that the NHS is now subject to radical reform, with the introduction of self-governing trusts, GP fundholders and an 'internal market'. On the other hand, even superficial comparison of the Russian and the British systems of health care shows deep distinctions. These can be summarised as follows:

i) Mechanisms of resource allocation have hitherto been concealed in Russia and have not been part of the political process.

ii) Primary medical care is based in state-owned medical facilities, rather than being provided by independent GPs.

iii) Hospital doctors in Russia play an insignificant role in management decision-making.

iv) Hospital budgets are based on bed capacity.

v) There are no organisations, outside of the State, to monitor and regulate health care.

vi) The private sector of health care is very small. Private services are provided mainly on the black market.

Traditionally the allocation of health care resources has taken place outside public control. State-owned enterprises and employees paid their taxes mainly to the central budget which was then distributed among different ministeries and institutions according to their influence and political power. Local governments lacked the power to levy taxes. The influence of the medical profession could not be compared with more powerful sectors of the economy such as the military. The absence of political choice for the population restricted public influence on budget priorities. As a result the health sector was financed by a "residual" method: as the last priority.

At the moment there are many signs of a shift in priorities. The medical lobby in parliament has increased and for the first time in our political life slogans for improving health care have been used in pre-election campaigns. The government has done its best to increase health

care expenditure but the economic situation makes it impossible to ensure a shift in budget priorities.

The crisis in the system is obvious. Health care expenditure amounts to 34% of GNP compared to 6.5 - 11% in Western countries. We have become known as "the sick man of Eurasia" (Health in the Soviet Union, 1991). We lack elementary drugs, materials and instruments and cannot pay doctors a decent salary. According to preliminary estimates of the Russian Federation Ministry of Health, the budget allotment to the health sector (in constant prices) in the second trimester of 1992 does not exceed 50% of the budget for the same period of the previous year.

In broader terms the state budget has turned out to be an unreliable source of finance for health care. The huge budget deficit means that it will be difficult to maintain the current level of funding of health care. Roaring inflation after liberalisation has devalued the rise in expenditure. The health system finds itself in an unfavourable situation as, unlike other branches of the economy, it cannot sell its services elsewhere.

There is a trend towards supplementing budget allotments with other sources of finance, for example from enterprises. It is believed that decentralising fund-raising will strengthen the financial base of health care.

The dominance of the state is an important feature of the Russian health system. Practically all medical facilities are state owned and directly managed by health authorities, and are not subject to the pressure of market forces. Unlike in the UK, there is no market for medical

equipment and pharmaceuticals in Russia. The bulk of these are distributed by the central, regional and district state bodies responsible for procurement of medical facilities. As a result hospitals and polyclinics[1] are very much dependent on health authorities and are subject to bureaucratic control. Only Now That radical reform has started health institutions can buy some equipment, but it is so expensive that most of them cannot afford to do so.

Compared to the NHS, the Russian health system is subject to more state control and lacks mechanisms of self-regulation and elements of competition. Both the finance and provision of primary medical care are functions of state institutions. The bulk of primary medical care is delivered by state health centres which were set up in the 1920s. During the nationalisation of medical care, doctors were thrown out of their private practices and became "Soviet office employees" working for low salaries in state polyclinics. They have lost their traditional autonomy from state authorities and their influence on management and decision-making.

Polyclinics serve a population of about 30,000 to 70,000 people. Every urban resident is assigned to and required to register with a specific local polyclinic for primary care. Polyclinics have both adult and paediatric departments. Antenatal and post-natal care is provided in polyclinics and maternity clinics.

Polyclinics have led to the development of a new type of doctor with neither the skills nor the incentive to provide comprehensive primary health care for his/her patients. Polyclinic doctors' salaries are 10-15 per cent lower than average wages and salaries and are not related

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1 Polyclinics are outpatient medical centres where patients receive primary care and attend specialist outpatient clinics. They can also have diagnostic tests and x-rays performed and receive physiotherapy etc.

to the volume or quality of medical care provided. As a result they tend to offer little direct medical care, preferring to refer patients to specialists in the polyclinics or at hospitals. The level of referrals is not known, but according to estimates of the Russian Federation Ministry of Health it amounts to 25-30 per cent of all visits, compared with 8-6 per cent in the UK, 7.9 per cent in the Netherlands, 5.2 per cent in the USA and only 2.8 per cent in France (Sandier, 1989).

Due to the low level of GPs' salaries, the primary care sector has been developing primarily by increasing the number of poorly qualified doctors. We have twice as many doctors on a per capita basis as in Western countries but it has not prevented a great shortage of medical care and insufficient preventative services.

The hospital sector is more similar to the (pre-1991) NHS. All hospitals are directly managed units. Hospital size range from an average of 36 beds in a local community hospital to over 900 beds in a regional hospital. The hospital sector is regionalised and divided between general and specialised hospitals. The vertical hierarchy of the sector includes local community hospitals serving communities of about 5,000 residents, rural and district hospitals for about 50,000 residents, city-centre hospitals for 200,000 residents and regional hospitals serving a population of two to three million people (Rowland and Telyukov, 1991). Private hospitals are non-existent.

All medical doctors are employees of a hospital (mainly full-time). There are no private consultants contracted to work for health authorities. Doctors are subordinate to the chief

doctor who performs the functions of hospital managers. The latter is subordinate to DHA managers.

The formula of budgeting for hospital services is based on the number of hospital beds. It is the simplest form of reimbursement of hospital care, and does not include any allowance for local needs or hospital performance. It does not offer any incentives to the providers of inpatient care - hospital managers, doctors, nurses, health authorities - or to the patient. A hospital does not receive additional funds if it increases patient numbers, nor are inefficient hospitals subject to reduced funding or closure. It is practically unknown for inefficient, poorly equipped hospitals to be closed down.

Enthoven's comment about the NHS, that is was more difficult to close an unneeded hospital than an unneeded military base, holds true for the Russian hospital sector (Enthoven, 1991).

Due to the method of reimbursement, increasing the supply of hospital bed capacity has been a priority of health sector development with greater emphasis on quantative rather than qualitative goals. Scarce resources have been allocated to the construction of new hospitals, and increasing bed supply and the number of doctors.

A particular characteristic of the Russian health sector is limited choice for consumers. All citizens are registered with their district polyclinic and assigned to a doctor who is responsible for the community. The same applies to hospitals. A patient is referred by a polyclinic to the district hospital. There are very few opportunities for patients to choose to which hospital they are referred.

The private sector is very small. Polyclinics and hospitals are allowed to charge patients for some minor services but the volume of this activity is less than 1 per cent of total health expenditure. There are some state polyclinics which render services only for fees but only 20 per cent of the demand for their services is met. A recent innovation in the health sector is a medical cooperative. These are private enterprises which exist as independent providers. Most of them are heavily dependent on hospitals because they cannot buy medical equipment and have to lease it from hospitals. Local health authorities or health managers can easily close cooperatives by refusing to rent medical equipment and premises to them. Medical cooperatives do not receive patients from state-owned institutions and no effort has been made to integrate them into the public health sector. Medical cooperatives have not been supported by the health authorities and are highly taxed. This is an unwise policy given that there are very long waiting lists in the state sector.

According to my estimate, official private health expenditure (including charges in the public sector) in 1990 amounted to only 3.7% of total health expenses which is much less than in the UK (Propper, 1990). At the same time there is an enormous black market for medical care, since some patients who are not satisfied with the treatment they are receiving are willing to pay a fee to a more competent doctor in a good hospital. My estimate is that illegal payments are at least eight times as much as legal private expenses.

Although our health system differs from the NHS in many respects, the main features of health sector reform are similar. The first main steps have been made in recent years. New approaches can be summarised as follows:

i) Decentralisation of finance and management; delegating management functions to RHAs and DHAs, widening the rights of hospitals and polyclinics.

ii) Funds allotted to regions and districts on a per capita basis.

iii) Reimbursement of hospital care on the basis of the population profile of patients, and polyclinics on capitation basis.

iv) Making polyclinics fundholders in three regions of Russia ("Leningrad experiment").

The first steps turned out to be promising but the need for more radical reform still exists.

2 A Comparison of State Tax-Financed and Health Insurance Markets

The Medical Insurance Act stipulates the transition to a comprehensive budget-insurance model which provides a guaranteed amount of medical care free at point of delivery to all citizens. Budget allocations are supplemented by contributions to the compulsory insurance scheme by industrial enterprises for their employees. The non-working population is insured through contributions from the government budget. The government guarantees implementation of basic health insurance programmes. Compulsory health insurance is supplemented by voluntary insurance (individual and group schemes).

Two issues arise in connection with the coming reform. Is the health insurance model more appropriate under the current economic and political situation in Russia? If the answer is

positive, which health insurance model should be made the core of the system - compulsory or voluntary?

2.1 State tax-financed vs. social health insurance model

Both models have their advantages and disadvantages. The (compulsory) social health insurance model has been chosen for several reasons. First, the insurance model is a less rigid and more open-ended system of raising money. Financing of health care is more responsive to local needs. The insurance contributions are earmarked; they are not paid into the general budget revenues but to a fund specified for health care. As a result, the health sector competes to a lesser extent with other budget allocations thus reducing the probability of health expenditure being sacrificed to other budget priorities. The specific allocation of health insurance funds is of special importance in Russia because for a long time health care has been a low budget priority. Although priorities are changing and the medical profession has gained better representation in parliament, the health sector still cannot compete with more powerful lobbies.

The insurance model ensures that the funds raised for health care are indeed used for that purpose. The collection and distribution of insurance funds is subject to public control. The insurance money comes back to the insured in the form of clearly specified medical benefits and is controlled by autonomous insurance bodies created to defend the interests of the insurers ("financial sponsors" in Enthoven's terms). Politically, a rise in health insurance contributions is more acceptable than a rise in income taxes.

Health insurance contributions are included in production costs. In the current economic situation this is of particular importance because after liberalisation of prices these contributions are comparatively easy to put onto the price of goods and services. The absence of international competition facilitates the process. The resulting price rise will be negligible in comparison with the rate of inflation. According to my estimates, made in the middle of 1991, the general consumers price index to that date would have risen to less than 10 per cent which would be negligible even at that time.

The inclusion of health insurance contributions within production costs will ensure an automatic influx of funds for the health sector. Each enterprise will participate in the formation of health insurance funds. This implies a redistribution of income to the health sector and to a certain extent conflicts with other priorities of economic and social policy, but it can be justified by the traditional underfunding of this sector.

One argument against health insurance is that under the current economic situation some enterprises will go bankrupt and will not be able to make health insurance payments for their workers. To ensure comprehensive social protection, the Act stipulates that the state pays for insurance for the unemployed from general budget revenues. To implement this we need some financial reserves. The other possible approach is to make health insurance contributions for the unemployed from unemployment insurance funds, which would cover both unemployment and medical benefits. The issue of an unemployment insurance system is being discussed in Russia but it is unlikely to be created in the near future. Therefore, the state budget will be the main source of finance for health insurance for the unemployed. However the burden on the state budget will still be much less heavy than at present.

Financing all health care will give way to government contributions for certain groups of the population, including the unemployed.

The future system of the health sector in the Russian Federation is designed as a budget-insurance model. In addition to contributions for the non-working population, the government will create health protection funds which will be governed by central and local health authorities. The main idea of creating these funds is to offer territorial health insurance schemes "insurance" against unpredicted risk and to equalise health care resources in different territories. Health protection funds will also be the source of finance of public health programmes, training of medical personnel, research etc.

The main characteristic of the health insurance model is lesser rigidity in fund raising. It is less reliable for unemployed people but in Russia's current situation it is more reliable for the overall population.

The second characteristic of the health insurance model is a split between the finance and provision of health care. The system has an independent intermediary or purchaser of medical care embodying public interest. At the moment an independent purchaser does not exist in the Russian health sector. Formally health authorities claim this role but in fact they are integrated with medical facilities and mainly express the interest of providers.

The introduction of a third party makes it possible to shift from an integrated to a contractual model of medical care. A fixed budget and guaranteed salaries for doctors and the staff of hospitals and polyclinics will give way to contractual relations between insurance companies

and medical institutions. The insurance companies, driven by economic interests and a commitment to the community, will choose the most competent doctors and the most cost effective medical institutions. They will contract not only with public hospitals and polyclinics but also with independent group practices, commercial hospitals, nursing homes etc.

Considering differing models of reimbursement, Hurst comes to the conclusion that countries with health insurance systems (France, the Netherlands, West Germany, Belgium) are more likely to use the contractual model of reimbursement of medical care, both in primary and hospital sectors. Countries with state tax-financed health systems (UK, Ireland, Spain, East Germany) tend more often to use the integrated model of reimbursement, particularly in the hospital sector. He also concludes that the integrated model is more likely to be associated with waiting lists and inadequate care (Hurst, 1991).

By building up the health insurance model, we are planning to shift emphasis to primary medical care, to attract the most competent hospital doctors to this sector and to support them with subsidies for setting up their own practices. A relatively small number of competent and economically motivated doctors will take the main burden of medical care. The Chinese type of "barefoot doctors" will be phased out.

An independent insurance organisation is more free to purchase medical care than the health authority. It can more easily reject the services of some facilities. On the one hand the health insurance organisation has economic interests in choosing the efficient units. On the other hand it has less of an obligation to existing state-owned medical facilities than has a

health authority. Personal relations between purchasers and providers are not as important as in the state health system. The division between finance and provision in the health insurance system is more clearcut.

It is also intended that health insurance will introduce tighter financial controls. The costs of medical care become visible and have to be kept within the contribution income. Providers of medical care are more interested in increasing efficiency and they have to bid for insurance funds. On the other hand, a health insurance organisation acting as a purchaser will be interested in collecting information about needs, demand and the performance of providers. We hope that the first and the most probable result of the transition to a new model will be increased demand for management information.

Strictly speaking, a market oriented approach or internal market is possible within any system. The main problem is the distribution of public funds, not raising these funds. The current reform of the NHS does not imply changing the model of fund raising. It is possible to form elements of market relations by separating providers and purchasers of health care and by allowing cross-boundary flows of services, thereby creating a multitude of buyers of medical care, but this approach is not sufficient for the Russian health system. We need deeper changes because we are tackling a more complex situation. Contrary to Western countries the aim of our reform is to make the health care model more open-ended because we suffer mainly from underfunding, not from cost escalation.

Furthermore, we are more interested in direct participation of employers and employees in raising funds. At present they pay income taxes which are not specifically for health care.

Employers lose the feeling that health care costs something. This is one of the reasons for ignoring health protection measures: enterprises can damage the workers' and citizens' health without incurring financial losses themselves.

In addition it is important to restructure the system of insurance for sickness pay. Employees' receive full pay after eight years of work. Sickness pay comes from the centralised insurance funds. In situations where there is a surplus of labour, employers are happy for workers to claim sickness pay as this saves them the worker's wage which can be diverted elsewhere, for example in the form of bonuses and incentives.

Medical insurance is aimed at increasing the responsibility of both employer and employees for health protection. It creates economic incentives for a healthy lifestyle and preventative health protection measures.

Considering the arguments for and against the health insurance model we recognise that the model itself does not guarantee improvements. New managerial and policy decisions are required. The main problem is how a new model will be implemented.

Health insurance will not overcome resource constraints. A shift of resources to health care will inevitably lead to a decrease of resources in other sectors. The decision to be made is a political one.

Summing it up we can suggest several criteria of evaluation of the health insurance model. The expected results of the reform are more secure funding, improvement in allocative and

technical efficiency, improved quality of medical care, new opportunities for consumer choice, more openness. The possible negative effects are less equity, additional cost of collecting money and conflict with other social policies.

Evaluation of the Health Insurance Model	
Positive Benefits	**Negative Benefits**
Secure funding +	Equity --
Allocative efficiency ++	Cost of collecting money -
Technical efficiency ++	Conflict with other social policies --
Quality +	
Consumer choice ++	
Openness ++	

Participants of the course "Health Economics for Eastern European Countries", organised by the Centre for Health Economics and Health Economics Consortium, University of York in January - March 1992, attached the largest weight to secure funding, allocative efficiency and quality and less weight to openness and consumer choice.

2.2 Compulsory vs voluntary medical insurance model

An important issue in the recent development of the health sector in Russia is the role of voluntary (private) medical insurance. There are many proponents of voluntary insurance, who suggest that the reforms should begin by introducing voluntary insurance which should be transformed into compulsory insurance in the later stages of reform. To some extent these

arguments are similar to some proposals which were put forward during the review of the NHS in the late 1980s. The line of argument was nearly the same: to decrease the burden on the state budget and to increase consumer choice. Eventually these proposals were rejected and the concept of an internal market within the NHS was chosen as the means of restructuring health care (Culyer, 1989).

In Russia voluntary health insurance cannot be regarded as a way to achieving social health insurance. The distinctions between the two types of insurance are so great that it is most unlikely that private insurance could be transformed into public insurance. The former is driven by commercial motives and uses specific methods of insurance rates setting, pricing of medical care and the choice of customers. These methods cannot be used in a system of social insurance. As a result private medical insurance will either develop parallel to the public system or (more probably) will undermine the public system by drawing resources from it.

The experience of private medical insurance in many Western countries, particularly in the USA, highlights the main disadvantages of the model, the most important of which is risk selection. The private insurer is interested in selecting low risk customers and rejecting the high risk. This distorts the principle of pooling risks and results in insufficient protection of high risk people (Van de Ven 1990). In the absence of competition private insurance carriers can pool the risks for community rating. They charge all the insured equally irrespective of their risks; the premium reflects the average risk of ill health for all insured. But in this situation low risk groups are discriminated: they have to pay for high risk groups and the price of their insurance premiums will be more than the price reflecting the real risks of being

ill. Sooner or later low risk subscribers realise that they are overpaying and will start searching for more beneficial options.

An insurance company may approach this problem in two ways. Firstly, it may attempt to impose premiums according to the level of risk attached. In this case high risk groups will have to pay more. As a rule, these are people with low incomes who cannot afford higher prices and some of them will be priced out of the market. Secondly, to the extent that a company is unable to define individual risk it may offer policies to attract specific low risk groups.

These approaches do not ensure protection of people with the highest need of medical care. Increasing competition in the private health insurance market undermines any efforts to increase risk taking. In the USA, health maintenance organisations' HMOs' performance has for some time been based on the community rating. But competing commercial insurance companies tried to offer lower rates of insurance premiums to low risk groups. As a result HMOs either had to reduce insurance benefits or differentiate insurance rates. A similar practice is exercised by Blue Cross and Blue Shield.

The second problem of private medical insurance is that it increases medical costs. This is well documented and must be taken into account in building up the system of health insurance in Russia. Administrative costs are prohibitive. In the US they are 25 per cent, as a great number of lawyers, accountants, insurance agents, inspectors etc are needed. Social health insurance does not require such administration costs, primarily because it doesn't differentiate risks.

Another characteristic of private medical insurance is the fragmentation of medical care provided to subscribers. With the exception of Germany and the Netherlands (where private insurance is designed for income groups who are not eligible for social health insurance and who can buy comprehensive medical insurance policies) private insurers offer insurance plans which cover a restricted volume of medical benefits. In the UK, private insurance companies cover selective surgery on pay beds in the NHS hospitals or commercial hospitals, services of consultants, nursing care, some diagnostic procedures etc. But all primary care and most secondary care are not included in private insurance plans. In other words, voluntary insurance is on the periphery of the system, supplementing the public sector.

Studying the experience of Western countries we are coming to the conclusion that private medical insurance is possible only within a clearly defined private sector provision of medical care and, to the maximum possible degree, is separate from the public sector. Private finance (voluntary insurance) serves private provision of medical care and cannot go beyond it. This conclusion is significant for Russia because private insurance companies tend to rely on the network of state-owned medical facilities, and do not differentiate between public and private provision.

Despite the disadvantages of private medical insurance there are some factors that make it relatively acceptable at least in the short term. First of all private insurance will be able to draw in additional money for the health sector. Under the pressure of the labour movement, state enterprises are becoming more responsive to employees' demand and people are becoming less hostile to the idea of public/private mix.

The other factor in favour of private medical insurance relates to the network of hospitals and polyclinics, so-called "medsanchasts", which were established by state run enterprises and, until recently, were run by them. Most of these institutions are better equipped and staffed than the average medical facility owned and governed by health authorities. Now, however, some enterprises cannot afford to run their "medsanchasts" and would be prepared to hand them over to the health authority. However, these are also financially unable to support them. The enterprises are, therefore, attempting to raise additional money for the "medsanchasts" and medical insurance is an acceptable means of doing this. Enterprises can create their own medical insurance companies or contract commercial insurance companies. In some industries employers are creating group insurance companies. This kind of voluntary group insurance comes close to the model of social insurance because it provides a degree of pooling risks and redistribution of income in favour of high risk groups.

Private medical insurance can benefit the most competent doctors who work in the best medical institutions. However, the average polyclinic and average doctor are unlikely to gain anything from private insurance because of limitations on the demand side. Employers and employees don't want to pay for the services of the district polyclinic. So far private medical insurers have shown little interest in primary care and this is distorting the structure of the health sector. However, there are the first signs of insurance companies providing primary care. In Moscow there is a medical insurance company "Family doctor", and in Kemerovo a medical insurance company "Komestra" sells a policy offering complete maternity care.

At the same time it is obvious that the development of private insurance will impede the introduction of compulsory medical insurance. Employers who now buy private insurance

for their employees will not be willing to participate in social insurance and will try to block it. Private insurance plans lead to an increase in medical care cost. Doctors who now contract with private insurers and enjoy high prices for their services are most unlikely to be advocates of social health insurance as the latter will never ensure a similar income.

Evaluating the pros and cons of voluntary medical insurance the Russian Federation Ministry of Health tends to support its development, but no effort has been made to monitor and control the insurance companies. Apart from the requirement of licensing insurance companies, there are no regulations controlling their activities and there is also no regulation of medical institutions which contract with insurance companies.

Two points should be kept in mind in shaping policy in this area. Firstly, it is necessary to regulate the development of the public and private sectors. Voluntary medical insurance plans must be coordinated with public provision and the distinction between the two should be regulated and controlled by health authorities. It is health authorities and not commercial companies who must shape the public/private mix, otherwise there will be an inevitable shift to the private sector. Secondly, every medical institution must be willing to undertake a certain volume of work for the public sector, but beyond this hospitals and polyclinics should be free to contract with private insurance companies. This will ensure that the state maintains control of the health system by setting priorities in the development of the public sector. The most important step now is to speed up the introduction of social health insurance. Compulsory medical insurance programmes will specify public obligations and thus define the market for private medical insurance.

3 Transition to a New Model

The Medical Insurance Act, which introduced the reforms in the health service, did not include details concerning the proposed reforms: for example, it did not specify the rate of income-related health insurance, the status of health insurance or the medical benefits covered by the health insurance model.

Despite the lack of detail, a decree by the President of the Russian Federation announced that voluntary medical insurance would be put into operation in October 1991 and compulsory medical insurance would be introduced in January 1993. The Russian Federation views it as an experiment.

It is still not clear what form the proposed health insurance model will take and the debate is focused on a number of issues which are discussed below.

3.1 Compulsory health insurance: free market or regulation?

A strong distrust of state institutions and government regulation has given life to a libertarian approach to the health service. It is asserted by many proponents of the market that health insurance must develop as a new commercial structure within a system of market relations. They resist state regulation of health insurance and any form of centralisation and redistribution of insurance funds. According to this approach medical insurance is considered to be a separate system outside the health sector. The Act gives a wide scope for interpretation of the new model and some of the points of the Act reflect the libertarian

approach, for example the provision that "medical insurance organisations are not part of the system of health care".

The other group of researchers and decision-makers involved in building up the new model view compulsory health insurance as a specific area of economic relations which cannot develop on the basis of commercial motives and market regulators. The main objective of compulsory health insurance is to ensure guaranteed social protection, which implies government intervention and specific forms of representation of consumers' interests. The autonomy of insurance organisations does not rule out interaction with health authorities within the overall health sector. A certain degree of centralisation of insurance funds is admitted. My personal view is that the second approach is more appropriate. It fully reflects the experience of health insurance in Western countries.

The US experience shows that the realisation of social programmes (Medicare and Medicaid) through the mechanism of private insurance does not given acceptable results. Acting in a competitive environment insurance companies do not have incentives to decrease costs. It is primarily quality and not price competition which is used to attract customers by new medical technology, amenities etc. Investment in new forms of accumulating insurance funds is more profitable than any cost effectiveness measures. Competition makes risk selection more probable and provokes cost escalation (Higgins 1991, Kirkman-Liff, 1990). In European countries with social health insurance systems the emphasis is on regulation. In France- Caisse National - the central body of the largest health insurance scheme - is responsible for planning and distributing resources between 129 local insurance boards. Insurance funds, acting as autonomous bodies, are still subject to administrative regulation by Caisse National

and the Ministry of Health. In addition the local prefect coordinates the activity of health insurance, medical and social institutions (de Pouvourville, Renand 1985, p 157).

In countries with decentralised health insurance models (Germany and the Netherlands) market forces are stronger. In Germany 50% of the insured can choose the insurance fund; this is a prerequisite of competition. According to Plaff, competitive forces are felt in the following interactions: insurance funds - doctors, doctors - insured, doctors - medical and pharmaceutical industries. But competition is weaker or non existent in interaction between insurance funds and hospitals and insurance funds and pharmaceutical companies (Plaff M, 1990, p 116).

Although there are moves in Western Europe to introduce competitive elements in to health care, it is generally agreed that the market model is inappropriate in the health sector and is not compatible with objectives of social policy and cost effectiveness. The conclusion of Maynard is that "whatever organisation exists and whatever the policy goals, regulation-by which is meant intervention by public and private interests to determine the prices, quantity and quality of health care-is unavoidable" (Maynard, 1985, p 164). This applies equally in Russia and leads us to reject radical approaches to reform.

3.2 For-profit or non-profit social health insurance bodies?

Proposals to hand out health insurance funds to for-profit insurance companies are not new. In Western Europe in the 1950s there was a proposal to grant each citizen the right to insure with a commercial insurance company. There was also a proposal to subsidise poor people

from the state budget. But this approach has been rejected for two main reasons - possible risk selection and cost escalation (Abel-Smith, 1990).

In most developed and developing countries compulsory insurance bodies have the status of non-profit organisations. They are subject to a non-distributional constraint, that is profit cannot take the form of dividends on share stock. The non-profit organisation is governed by a board of trustees which consists of representatives of all interested groups - employees, trades union, medical associations, health authorities and, sometimes, consumer organisations.

A classical model of health insurance differentiates between compulsory and voluntary insurance operations. The former are usually performed by non-profit organisations and the latter by commercial bodies. This division stems from the basic distinction between the two types of health insurance. Amalgamating them runs the risk of encouraging more voluntary insurance business at the expense of basic insurance programmes. At the same time, we must admit that in many countries there is a tendency to converge the two types of insurance. Compulsory insurance bodies are allowed to perform private insurance and the private insurance companies are interested in social insurance. Both trends are particularly explicit in the Netherlands.

In the Russian Federation the Medical Insurance Act does not make provision for the non-profit status of compulsory health insurance organisations. The emphasis is placed on the existing legal structures - state and private for-profit enterprises. The latter are most unlikely to take up compulsory health insurance while they are still profiting from voluntary insurance.

But even if they take it up it is unlikely to be a reliable form of social protection since commercial companies will find many ways of reducing their social obligations.

Commercial motives must not govern this type of operation. We need public organisations to be responsible for compulsory insurance. Non-profit organisations can be a reasonable alternative to both state and for-profit private structures. Non-profit organisations rely on a board of trustees as a form of public interest representation. The economic motive is mitigated by the non-distributional constraint. Non-profit organisations will be responsible for a redistribution of social insurance funds to the highest priorities of medical care for the groups of population with greatest needs.

It is important to separate compulsory and voluntary medical insurance. In my view, special bodies must be created which will be solely responsible for compulsory insurance. In any case, it is reasonable to start with a more rigid model and only then to explore an option of a mixed model.

3.3 Health authorities and health insurance bodies: opponents or partners?

Mistrust of state agencies in Russia has led many people to the belief that health insurance bodies are an alternative to health authorities. They place an emphasis on their independence and freedom from state intervention. Insurance organisations are hostile to the idea of regulation and the division of functions. On the other hand, many local health authorities tend to be distrustful of insurance bodies. They are afraid of losing administrative monopoly and of the possible diversion of resources from the public sector.

A similar distrust occurred in many developed and developing countries in the early stages of creating health insurance systems. But step by step this distrust has been overcome as both sides have recognised the need for cooperation. Governments have seen in health insurance a new way of attracting money to supplement public funds and the state bodies have retained the most important functions of planning resources and the regulation of health facilities. The functions of health authorities and insurance bodies have not overlapped. Ministries of health have come to the conclusion that the system can be kept under control and have preferred to treat insurance bodies as a partner with potential to support innovations (Ron et al, 1990, p 30). On the other hand, health insurance bodies have understood that their commitments to the insured can only be met by appropriate planning of resource allocation and this has encouraged cooperation with the health authorities.

Health insurance in developed and developing countries is a sub-system of the health service. The partnership is implemented by representation of health authorities on the boards of trustees of insurance bodies, by participation in-setting insurance rates, rates of reimbursement of medical care, medical benefits etc. Ministries of health are usually responsible for supervision of health insurance systems. At the same time, insurance organisations tend to cooperate with health authorities in the supervision of medical insurance programmes, control and use of resources and cost containment programmes.

In Russia we need the real participation of health authorities in building up socially responsible health insurance bodies. It is they who must initiate the creation of such bodies. The best approach is to remove finance departments from health authorities and grant them

an independent legal status. State authorities must start the process and then step aside to give the new compulsory insurance organisations an opportunity to perform on their own.

In the further stages of the implementation of the reform, health authorities have to supervise the insurance system, coordinate compulsory and voluntary insurance in order to prevent a shift from the public to the private sector, and ensure the fulfilment of the Medical Insurance Act. Health authorities must play the main role in planning health resources, choosing a balanced public/private mix, accreditation and licensing of medical facilities, quality assurance, assessment of needs and monitoring of health facilities performance under health insurance programmes. They must control the overall development of the health system.

3.4 Universal or separate health insurance programmes?

In the process of creating an insurance system, it is important to resist the temptation of making promises about universal benefits. In Western countries the process of building up an insurance system has taken several decades. It has been the process of transition from charity health to a system financed from earned income. In each stage the medical benefits offered to the insured have been matched with the financial resources available. Historically, user charges have decreased as a result of drawing additional money into the system. In the mid-70s the opposite process began. An incremental integration of medical insurance into the health system has taken three main directions - increasing the number of enterprises which participated in insurance; spreading medical insurance over new areas; and widening the volume of medical benefits. The first insurance programmes covered hospital care expenses, then programmes were introduced covering primary care, dental care, pharmaceuticals etc.

However such an approach has been undermining equity of access. Some regions, enterprises, and social groups have enjoyed higher benefits at the price of increasing inequity. In the early stages of implementation of the reform this process is likely to be inevitable. But in the process of widening the range of health insurance programmes inequity has been reduced. Equity considerations have been of vital importance in all countries.

The world experience shows the need to be very cautious in choosing the range of medical benefits. Insurance programmes must provide realistic benefits. In Russia, in my view, the creation of a universal insurance system is unrealistic. It is better to start with one or two programmes in territories which are better prepared for such innovations. These are territories with experience of contracting, collecting management information, quality assurance and monitoring of provider performance. Such an approach has been chosen in Kemerovo region. The insurance system will first be confined to hospital care; polyclinics are going to contract with health authorities.

The other possible approach is to start with insurance programmes of pharmaceutical care. The accumulated insurance funds are intended to support the pharmaceutical industry, to make the production of drugs more profitable.

3.5 Centralised or decentralised health insurance system?

The health insurance system cannot be structured along the lines of the existing centralised system. The objective of a new system is to make it more responsive to local needs and centralised insurance at the level of the Russian Federation will not enable us to achieve this

objective. At the same time it is impossible to create a highly decentralised system since it does not meet the principle of solidarity underlying social insurance. Some local communities are unable to raise insurance funds to guarantee even basic medical benefits because they lack the industrial base to make contributions. Besides that it must be borne in mind that the system is being developed during an economic crisis when resources are particularly scarce. As a result some concentration of resources is inevitable, because it is the means of achieving minimum benefits for all.

3.6 Universal or differentiated rate of compulsory insurance payments?

Differentiated rates of compulsory insurance payments can be used to reward employers who introduce health protection measures for their employees. The Act stipulates that employers can enjoy a lower rate of insurance premium if the mortality and temporary disability of employees is stable or decreases during a three year period. It is possible to estimate the proportion of disability which is explained by the social and demographic characteristics of employees; the remainder is considered to be due to working conditions. Such estimates can be used to establish a scale of differentiated rates of insurance premiums.

Although it is possible to introduce a differentiation of premium rate within industries, since enterprises in Russia do not work in a competitive environment they can shift health insurance costs forward onto the prices of goods without risk of losing their market position. There is therefore no advantage in the introduction of differentiated rates.

Efforts to create a differentiated scale of insurance rates for different industries have proved more controversial since, for example, some essential industries have less safe and healthy working environments than other enterprises. Differentiation between industries should reflect the possible impact of insurance rates on the price of finished goods and the priority of goods (with food being highest priority) should be the criterion to establish the correct differentiation of rates.

3.7 The basic health insurance programme

According to the Medical Insurance Act the basic health insurance programme provides for a guaranteed minimum of medical benefits. The programme is worked out by the Ministry of Health and authorised by the Government of the Russian Federation. Territorial health insurance programmes are based on the basic health insurance programme and supplement its benefits. The Ministry of Health and some regions have started elaborating the basic and territorial health insurance programmes. The main issue for them is to resist the temptation of including over-generalised medical benefits in the programmes.

In the current economic situation the Ministry of Health may have to reduce some medical benefits which are not of vital importance. It is important to secure the maximum possible social protection for pensioners, children and socially disadvantaged people.

It is most likely that we shall have to introduce charges for some types of medical care which are of lesser importance. This is a very painful process with a lot of social and political

consequences. The private sector is developing very quickly and the objective of the Ministry of Health and regional and district health authorities is to keep it under control.

Possible approaches to restricting the benefits of the public health sector were presented by John Roberts, Regional Programme Manager of the World Health Organisation in his lecture to the Course "Health Economics for Eastern European Countries" in York. They include:

i) removal of dental care from the public sector;

ii) restriction of ambulance services to emergencies, all other use to be charged for;

iii) some charges for laboratory services;

iv) reduction in the range of drugs to be reimbursed from public funds;

v) establishment of targets for cost containment for all services;

vi) reduction in admissions to hospitals for unnecessary and low priority treatment, diagnosis and care;

vii) reducing demand for low priority services by introducing user charges;

vii) exemption of chronically sick people from user charges.

Similar approaches are now being discussed in Russia. The first version of the basic health insurance programme made by the Ministry of Health stipulated for cuts of some medical benefits of less vital importance, including dental care for adults. However, even modest cuts in medical benefits cause great resistance at all levels of decision-making. At present the Government is avoiding explicitly defined obligations, however sooner or later promises will have to give way to specific commitments in order to prevent an uncontrolled shift from the public to the private sector.

4 A Regional Compulsory Health Insurance System

At the moment different approaches to building regional compulsory health insurance are being discussed. One of them to be started experimentally in Kemerovo region is based on the idea of centralisation of insurance funds within the region and their distribution to competing health insurance companies. A proposed approach (Sheiman et al, 1991) will most likely start to be implemented in Kemerovo region in Spring 1992. Some elements of the scheme are similar to the "Dekker plan" in the Netherlands. A group of Dutch experts headed by Professor van de Ven consulted the project in Moscow and agreed to participate in its implementation. The meeting in Moscow has been arranged by the Foundation for International Studies of Social Security (Secretary Han Emanuel) and financed by the Dutch government.

The central health insurance organisation (CHIO) is responsible for organisation of health insurance at regional level. It accumulates a regional health insurance fund through contributions from enterprises and local authorities. Enterprises make income-related

contributions for employees and local authorities pay flat-rate premiums for the non-working population. The insured do not make contributions. Cost-sharing is prohibited now mainly for political reasons, but it is likely to be introduced later in the process of a new income policy implementation.

In addition to CHIO a network of local insurance organisations and companies is being developed which will fulfil the bulk of health insurance operations. According to the Medical Insurance Act each resident chooses an insurance organisation and registers with it. The insurance organisation cannot refuse to register an applicant.

Insurance organisations are financed by the CHIO from the regional health insurance fund according to the number and profile of people insured by them. Insurance organisations are legal entities and are not subordinate to the CHIO. Most of them are independent state or private non-profit organisations. For-profit insurance companies can also participate in compulsory health insurance schemes.

The raising and distribution of health insurance funds are carried out according to the rates authorised by the local administration. In addition to its main function the CHIO also insures residents who don't register with local insurance organisations. This secures the comprehensiveness of the system; all citizens of the region are eligible for compulsory health insurance. Direct insurance without centralisation and redistribution of health insurance funds makes comprehensiveness impossible.

The advantage of this scheme is that it enables a reasonable combination of centralisation and redistribution with competition between insurance companies. The more people insured by the company the more funds they receive.

It is important that a proposed scheme restricts risk selection. The rates of insurance contribution are set irrespective of risks on the community rating basis. They are related to income alone. The insurance companies receive risk-adjusted sums per capita payment. In theory insurance companies are indifferent to the risks of those insured with them because they are going to get funds from the CHIO which takes this into consideration. But in reality 'cream-skimming' is still possible and it is important to work out a formula of payments which would restrict risk selection to the minimum (van de Ven, 1991).

The CHIO is most likely to be a state or private non-profit organisation. The board of trustees includes representatives of the local authorities, trades union, employers, health authorities, consumer organisations.

CONCLUSION

The dismantling of the state health system in Russia is currently under way and there is a pressing need for the introduction of a reformed health service. The urgency of jthe situation precludes the possibility lengthy discussions and preparations such as took place in the UK prior to April 1991. Transition to a new model of finance and organisation of medical care is inevitable. It is intended to preserve public commitment to health service praesen, but at the same time to make the health sector more competitive and responsive to local needs.

The Ministry of Health and Health Protection Committee of the Supreme Soviet of the Russian Federation are trying to persuade Parliament and the government to implement the Medical Insurance Act as soon as possible. There are some signs that their efforts will be successful. However mere is opposition from two fronts. The first group opposing the reforms is represented by the conservative wing of health authority managers (including Ministry of Health Managers) who do not want to lose centre of decision-making and resource distribution.

They are supported by incompetent medical staff who fear may will be dislodged by market forces. On the other hand there is opposition from radical reforms who argue that state health authorities should be abolished and replaced by a social insurance system based on commercial insurance companies.

Both approaches are inappropriate. It is necessary to establish a health care model which combines state regulation with competition between health service providers and health insurance companies.

The Ministry of Health has started to implement the proposed reforms. A set of guidelines have been prepared covering regulations on the accreditation and licensing of medical institutions, the basic programme of medical insurance benefits, the status and funding of federal and regional compulsory medical insurance organisations and the standard procedure for costing and pricing. These documents will form the basis for negotiating contractual relationships between insurance companies and medical institutions and it is hoped, will introduce new incentives for health care providers.

The transition to the model will be gradual and will take some time. However in some areas which have been experimenting with financial systems recently. The shift to the new model will be a natural contribution of these developments.

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