

The Priorities of Russian Health Care Reform

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Abstract

The introduction of health insurance system has been the core of the Russian health care reform. It has coincided with the decentralization of the state administration. So the reform has been decentralized, and the transition has been fragmentary and incomplete. As a result, the existing health finance system is eclectic and contradictory. Meanwhile the reform has had a positive stabilizing influence on financing of health care under conditions of continued economic crisis. The new priorities of the reform should be to balance the financial flows and the state's obligations and to increase the efficiency of the use of resources through encouragement of competition, assurance of transparency of public funding, development of health care planning, and shift from inpatient to outpatient care.

1. Introduction

Under planned economy, the health care in Russia was characterized by underfinancing and inefficient allocation of resources, overcentralized state regulation of medical services providers and few incentive to use resources efficiently, slow improvement of quality and lack of responsiveness to consumers (1,2,3). In 1990 total health expenditure represented in Russia 3.0 per cent of the GDP, while in established market economies - 9.2 percent (4). Per capita health expenditure was equal in Russia 157 US dollars in 1990. That was in 11.8 times less then in established market economies (4).

The reform of the Russian health care has been in progress since 1988. It has had a narrow framework concentrating mainly on the financial issues. Initially, the regulation of the budgetary financing of health care was suggested, as well as the extension of the rights of medical institutions in solving economic problems (1,2). Later on, in 1991, the policy of radical substitution of the budgetary health care system by health insurance system was proclaimed. The design of health insurance system, the obstacles to its introduction, the first results, and the failures of the reform has been already discussed (2,5-8). Meanwhile the political economy of the reform hasn't been highlighted.

The objective of this paper is to provide an overview of the health finance reform in Russia with accent on political economy issues. The paper examines the implementation of the reform by the government during 1991-1997. This is followed by an overview of key problems of health finance, which have to be solved on the next stages of the reform. Finally, the declared in late 1997 by the Russian federal government ways of solution of these problems are highlighted and discussed.

2. Transition from the Budget System of Health care Financing to the Insurance One

2.1. The Health Insurance Legislation

The introduction of health insurance started in Russia in 1991, just before the disintegration of the Soviet Union. The health insurance was expected to solve the problems of increasing resources and volumes of the health care financing (5). Ideological factors also had a significant impact upon this selection (6). Ideas on the necessity of the introduction of radical economic reform and decisive transition to market economy were also effecting the field of health care. Health insurance was considered a health care system maximally conforming to the market economy, as a means to create market environment for medical institutions in order to improve the quality of medical service and the use of resources.

The introduction of health insurance was initiated by the progressive part of medical officials. The bodies controlling health demanded a radical reform of health care financing and organization systems in order to defend their legal interests. In June 1991, the Act On Health Insurance of the Citizens of the Russian Federation was adopted (9) and amended (10) in 1993. According the Act, the principles of financing the new system of health care were as follows:

- The employers transfer insurance premiums for compulsory health insurance of active population; the premiums have tax character.
- Insurance premiums for compulsory health insurance of non-active population are financed by the state bodies from the budget resources.
- The extent and conditions of free medical services within the framework of compulsory health insurance are defined in the basic (national) compulsory health insurance program confirmed by the government, and in regional compulsory health insurance programs adopted by the regional authorities and conforming to the basic program. The volume of insurance premiums is established in accordance with the adopted compulsory health insurance programs.
- Functions of insurers should be implemented by health insurance carriers which are independent from the health care administrative bodies and medical institutions. The insurance carriers contract with employers for the insurance of their employees and with medical facilities for medical services provision. The use of private insurance carriers was considered a mean to create "quasi-market" and purchaser competition in health care. However, the reasons for this model were more ideological than rational (7).
- Apart from the compulsory health insurance, voluntary health insurance from the resources of the companies and private resources of the population can also take place.
- Federal and regional funds for compulsory health insurance (compulsory health insurance funds) are created as special state agencies for the collection and accumulation of compulsory health insurance premiums. The legislation defined the compulsory health insurance funds as independent, state, non-commercial, credit, and financial institutions. Their managing boards include people's deputies, representatives of regional administration, medical associations, trade unions, etc. The compulsory health insurance funds are accountable to the regional administration and representative administrative bodies, but they are not subordinate to the health care state bodies in administrative respect.

According to the legislation, compulsory health insurance funds and their local subsidiaries do not completely substitute regional and local health care administrative bodies. The latter retained the function of administration of the medical facilities which are under their property rights. The

regional health care bodies still finance the material and technical basis of health care, training of the personnel, activities of specialized medical institutions (tuberculosis dispensaries, psychiatric hospitals, etc.), prevention of epidemics, and other activities concerning public wealth. The sources are provided by the budgetary allocations. However, the federal legislation did not make a clear distinction of functions and management between the state health care bodies and the compulsory health insurance funds. The scope of activities and the field of responsibility of the compulsory health insurance funds became in practice dependent on the position of regional authorities.

2.2. The Decentralization of the Reform

The introduction of health insurance has coincided with the decentralization of the state administration. After disintegration of the Soviet Union in 1991, the governmental management of the social services' provision and of the health care in particular was decentralized. Regional health care administrative bodies became administratively independent of the Federal Ministry of Health Care. The Ministry directly administers/finances only the medical institutions that are federal property, carries out certain controlling functions, and establishes federal requirements to state licensing and attestation procedures of medical institutions, etc.

Regional authorities manage medical institutions over which they own property rights; local authorities administer municipal hospitals and outpatient clinics. Dependency of the lower executive bodies on the higher ones remains only where the latter possess and can distribute the means apart from financing the institutions which are under their property rights. The vertically integrated system of health care was divided into federal, regional, and municipal systems.

Decentralization had a great influence on the health care reform. Federal bodies could not at that time use the administrative methods for the introduction of compulsory health insurance. Meanwhile, the rights and the responsibilities of the federal and regional authorities for the implementation of the reform remained ambiguously defined in legislation. The process of creation of health insurance infrastructure became dependent to a great extent on the position of regional authorities.

The emergence of health insurance carriers and their integration within the compulsory health insurance system were slow and inconsistent. Health insurance carriers increasingly emerged and deployed their activities in those areas where regional authorities actively supported and introduced the new health care financing model. However, these regions constituted the minority. Most governors and heads of regional health care bodies supported the introduction of compulsory health insurance only in the aspect related to the transformation of financial inflows to the field of health care, but they postponed the transformation within the framework of the existing system of health care state management. Introduction of the compulsory health insurance funds acting as state institutions was for them more acceptable. As a result, the regional compulsory health insurance funds were granted the rights not only to transfer insurance premiums to the health insurance carriers but also to act as insurers and have direct interrelations with medical institutions.

The Changes in Public Funding of Health Care

Since the second half of 1993, the employers have been obliged to transfer insurance premiums for health insurance of their workers in the amount of 3.6% of their payroll funds. These resources started to be accumulated on the accounts of regional compulsory health insurance funds (3.4%) and federal compulsory health insurance fund (0.2%). By the beginning of 1994, 79 regional compulsory health insurance funds and 587 of their subsidiaries were created, 164 insurance carriers were included into the compulsory health insurance system (11).

Since 1994, the compulsory health insurance system has been officially introduced all over the country (12). The heads of the Ministry of Health Care of the Russian Federation struggled for the introduction of compulsory insurance premiums, but they made no efforts in order to reform the

system of interrelations within the framework of the branch. When the Ministry managed to introduce premiums for compulsory health insurance, it practically impeded the work in the field of developing the legal and regulatory basis of compulsory health insurance. The control over the reform was neglected, and the reform was decentralized.

After the introduction of compulsory health insurance, regional and local authorities immediately started to reduce expenses for health care from their budgets substantiating this by the fact that health care had acquired a new financing source. In 1994, the volume of state budgetary financing of health care in comparable assessment was reduced by 19.7%, and by 26.8% in 1995 compared to 1994 data (13). The expectations of medical workers that the insurance provided by companies would become an additional source of money besides direct budgetary financing failed. Budget financing of health care was not subsidized by insurance premiums but was partly substituted by them.

Table 1. The share of health care spending in all budget expenditures (percent).

	1993	1994	1995	1996	1997
Federal budget	1.7	1.6	1.3	1.2	2.2
Regional budgets	17.5	15.7	15.3	15.1	14.8

Source: Refs. 13,15, Federalnoye Kaznacheystvo. Otchet ob ispolnenii budzhetov v Rossiyskoy Federatsii na 1 yanvarja 1998 goda. Moscow, 1998. Unpublished data.

Table 2. Structure of public health funding (percent)

	1992	1993	1994	1995	1996	1997
Federal budget	11	9	10	7	6	10
Regional budgets	89	76	72	75	74	71
Compulsory insurance premiums	-	15	18	18	20	19
Total	100	100	100	100	100	100

Source: Refs. 13-15, Federalnoye Kaznacheystvo. Otchet ob ispolnenii budzhetov v Rossiyskoy Federatsii na 1 yanvarja 1998 goda. Moscow, 1998. Unpublished data, Gosudarstvennyi Komitet Rossiyskoy Federatsii po statistike. Otchet o raskhodovanii sredstv gosudarstvennykh vnebudzhetnykh fondov za 1997 god. Moscow, 1998. Unpublished data.

In 1993, the first year of the introduction of the payroll tax for compulsory health insurance, the public funding of health care increased by 35% (13). However, it has been constantly decreasing since 1994. In 1997, there was a decrease of 27% compared to 1993 data (13-15, Federalnoye Kaznacheystvo. Otchet ob ispolnenii budzhetov v Rossiyskoy Federatsii na 1 yanvarja 1998 goda. Moscow, 1998. Unpublished data, Gosudarstvennyi Komitet Rossiyskoy Federatsii po statistike. Otchet o raskhodovanii sredstv gosudarstvennykh vnebudzhetnykh fondov za 1997 god. Moscow, 1998. Unpublished data.). The situation in health care financing is much better than the one in the state financing of other social services. During the 1991-1997 period, GDP decreased in the comparable assessment by 38% (14,15). The public financing of health care was reduced by 21% in

the comparable assessment, whereas the corresponding figures were 36% for education and 40% for culture (13-15, Federalnoye Kaznacheystvo. Otchet ob ispolnenii budzhetov v Rossiyskoy Federatsii na 1 janvarja 1998 goda. Moscow, 1998. Unpublished data, Gosudarstvennyi Komitet Rossiyskoy Federatsii po statistike. Otchet o raskhodovanii sredstv gosudarstvennykh vnebudzhetnykh fondov za 1997 god. Moscow, 1998. Unpublished data.). The introduction of compulsory health insurance has had a positive stabilizing influence on financing of health care under conditions of continued economic crisis. The health reform resulted in the redistribution of public expenses in favor of health care. Public expenditure on health care represented 92,2 trillion rubles or 3.4 per cent of the GDP in 1997. Per capita public health expenditure was equal 108 US dollars.

Table 3. Public expenditure on health care in GDP (percent)

	1991	1992	1993	1994	1995	1996	1997
Total	2.9	2.5	3.7	3.9	2.9	3.1	3.4
- state budget	2.9	2.5	3.1	3.2	2.4	2.5	2.8
-compulsory insurance premiums from employers	-	-	0.6	0.7	0.5	0.6	0.6

Source: Refs. 13-15, Federalnoye Kaznacheystvo. Otchet ob ispolnenii budzhetov v Rossiyskoy Federatsii na 1 janvarja 1998 goda. Moscow, 1998. Unpublished data, Gosudarstvennyi Komitet Rossiyskoy Federatsii po statistike. Otchet o raskhodovanii sredstv gosudarstvennykh vnebudzhetnykh fondov za 1997 god. Moscow, 1998. Unpublished data.

Table 4. Public expenditure on health care in GDP (1991 = 100 percent)

	1991	1992	1993	1994	1995	1996	1997
GDP	100	85	78	68	65	62	62
Public health expenditures, total	100	80	108	98	72	71	79
Health funding from state budget	100	80	91	81	59	57	65
Compulsory insurance premiums from employers	-	-	17	17	13	14	14

Source: Refs. 13-15, Federalnoye Kaznacheystvo. Otchet ob ispolnenii budzhetov v Rossiyskoy Federatsii na 1 janvarja 1998 goda. Moscow, 1998. Unpublished data, Gosudarstvennyi Komitet Rossiyskoy Federatsii po statistike. Otchet o raskhodovanii sredstv gosudarstvennykh vnebudzhetnykh fondov za 1997 god. Moscow, 1998. Unpublished data.

The Conflicts between the Actors

The introduction of a new financial channel into the health care has resulted in the appearance of the elements of dual power in the management of health care system. The resources which were at direct disposal of medical functionaries have decreased. The health care officials could no longer give direct instructions to the compulsory health insurance funds how to spend the accumulated resources. Moreover, the health care administrative bodies had to compete with the regional compulsory health

insurance funds for budget resources in some regions.

In comparison to the health care administrative bodies, the compulsory health insurance funds have had sufficiently less formal restrictions on the spending of their budgets. Medical functionaries criticized substantial expenses of compulsory health insurance funds for buying low-priority items, such as PCs, cars, as well as expenses for the growing administration. In 1994, the latter amounted to 3.2% of the funds' total expenses (15). As a rule, conditions of payment and work in the funds and in the health insurance carriers turned out to be better than the ones in the health care bodies. Naturally, this caused annoyance. The conflict of interests was reinforced by the claims from the federal compulsory health insurance fund to consolidate compulsory health insurance funds into an integrated system. This could imply a vertical health care management structure parallel to the existing one.

Since the second half of 1994, most of the regional health care bodies, supported by the employees of the medical institutions, have started to demand the right to control the spending of resources received by the compulsory health insurance funds. The heads of the Ministry of Health Care were also reluctant towards the transformations that were carried out. However, in some of the regions, state bodies did not change their positive attitude towards the reform. It is nevertheless interesting that the chosen model of compulsory health insurance was supported in those regions where the financial situation was better and where the administrative capacity of regional authorities was higher.

In 1995 and 1996, top medical officials tried to initiate the revision of the Health Insurance Act. There were attempts to reestablish the state system of health care financing by abolishing the autonomous status of compulsory health insurance funds and turning them into the agencies accountable to health care administrative bodies, and by excluding private insurance carriers from the system of public health care financing. These attempts were blocked in the Parliament by active lobbying of the new special interest groups: associations of insurance carriers and compulsory health insurance funds, headed by the Federal Fund. Meanwhile, some regional authorities, by their own decisions, revised the health insurance model introduced by the federal law. For example, in 1996, in the Republic Marii El, and in 1997, in the Kursk region, the private health insurance carriers were excluded from the compulsory health financing system (13,16).

When the Minister of Health Care, the opponent of health insurance system, had been dismissed in the second half of 1996, open attacks on the compulsory health insurance funds and on the health insurance carriers ceased. The situation in health care has been marked by a rough balance of forces among the three groups of actors: medical administrators, compulsory health insurance funds, and health insurance carriers. In this context, any revision of the legislation regulating health insurance becomes a problem. The situation is currently unstable.

3. Unresolved Problems

3.1. Fragmentariness and Incompleteness of the Compulsory Health Insurance Introduction

The basic model of health insurance defined by the Federal Act on Health Insurance of the Citizens of the Russian Federation (9,10) has not been completely introduced in any of the regions. In fact, a new channel of health care funding has been institutionalized. The system of state agencies for collecting the new payroll tax for health insurance, i.e., the system of the regional compulsory health insurance funds and their local subsidiaries has been implemented. Regarding other elements of compulsory health insurance system, the eclectic combination of the elements of old state financing and the new insurance system has taken place instead of consecutive transition from one system to another. Substantial regional differences in the pace and extensiveness of transformations have taken place resulting in the present mixed picture of regional "models" of such a combination.

In 1996, the insurance carriers have really become the only intermediaries between insurers and medical institutions in the implementation of the compulsory health insurance program in 11 regions (out of 89 included in the Federation) (11). In other regions, the functions of insurance were fully or partially executed by the regional compulsory health insurance funds themselves or their subsidiaries. In 1996, the budgetary resources were transferred to the compulsory health insurance funds as the premiums for non-active population only in 67 regions (11). However, they were not transferred in the complete volume. The budgetary payments for the insurance of non-active population transferred to the compulsory health insurance funds constituted 44% of the insurance premiums paid by the companies in 1996 (15). The number of non-active population amounted to 123% of the employed. There was one important reason for the diversity of transitional "budget-insurance" models apart from the decentralization of the reform and lack of central control in its implementation. The revenues accumulated by compulsory health insurance funds were not sufficient to cover the gap between the available funds and those required to provide free medical services granted to people by the government. The region must balance the compulsory health insurance financing with the number of health care providers and the set of medical services financed by compulsory health insurance funds. Each region has individually established such balance.

According to the data from the Russian Federation Ministry of Health Care and Medical Industry (Ministerstvo zdravookhraneniya i meditsinskoy promyshlennosti Rossiyskoy Federatsii. *Analys realizatsii Zakona RF "O meditsinskom strakhovanii grazhdan v RSFSR"*. Moscow, 1995. Unpublished data.), in 18% of the regions only inpatient treatment was financed from the compulsory health insurance funds in 1994. On the contrary, in some other regions only outpatient treatment was financed.

3.2. Poor Coordination of Actions of Different Actors

The situation in the Russian health care is characterized by the appreciable cutting down of the possibilities to regulate the health care system, to realize the public interests and to influence the processes going on in this sphere. The decentralization of the state administration in combination with the fragmentary introduction of health insurance have been accompanied by the washing away of the responsibility of regulating bodies for the health care policy. The complex approach to health care has been lost. The creation of effective health care system demands the reform of the state administration system and learning the methods of regulation conformed to the principles of the federalism.

The existing delimitation of authorities and responsibilities among the executive bodies on different levels of the state system and the funds of compulsory health insurance is indistinct and irrational. The poor coordination of the policy of various actors in health financing system has resulted in an inefficient use of material and financial resources. There are few reasons for hope that the problems of coordination of different actors in the system of health care financing will be automatically resolved regarding the improvement of economic situation, and that the activity of insurers will ensure the effective allocation of resources. This is supported by the experience of China (17).

3.3. Failure of Competitive Insurance Model

The Russian model of compulsory health insurance has caused a competition among insurers and providers of medical services. There is a division of the spheres of influence rather than a competition among insurance carriers. According to the estimation of Federal Compulsory Health Insurance Fund, in 1997 no more than 150 out of approximately 500 insurance carriers in the system of compulsory health insurance operated as more or less active purchasers, whereas others were passive translators of funds from compulsory health insurance funds to medical facilities (18).

The typical situation is the absence of conditions for providers' competition because of the local

monopoly of medical facilities. In a situation characterized by a highly monopolized supply system of medical services, only inhabitants of large cities have a chance to choose hospitals, clinics, and physicians. Competition exists only on the medical service market covering voluntary health insurance. However, this market embraces only a small number of people with high incomes. The expected positive results from the activity of new actors in the health finance system (more control over the performance of providers and protection of patients' rights, increase in allocative and technical efficiency, etc.) have not been distinctly demonstrated. This is why most of the health officials and employees consider both the compulsory health insurance funds and insurance carriers as unnecessary elements in health financing. The opponents argue that new health finance system cannot demonstrate its advantages in the situation of its partial introduction and the gap between public guarantees and their funding.

3.4. Gap between Public Insurers of Free Health Care Provision and Public Health Spending

Russian state inherited from the epoch of socialism a wide range of social services guarantees and numerous state and municipal medical facilities. The citizens' rights to free medical services were formulated in the Constitution of the Soviet Union in very general terms. The package of medical benefits guaranteed to every citizen was not defined by the law. In fact, it included the citizens' rights to free medical services delivered by public medical facilities accessible to them. However, different medical facilities with different scope and quality of services were accessible to persons with different social status and citizens of different regions. These guarantees have never been changed; they were confirmed by the Constitution of the Russian Federation adopted in 1993. The situation should be changed after the introduction of health insurance system. The public commitments to the coverage, eligibility, and comprehensiveness of health care under compulsory health insurance are still too declarative and are not based on an actuarial approach (8). The basic program of compulsory health insurance was also formulated in general terms and was not balanced with financial resources. The premiums for compulsory health insurance of working population, established as a 3.6% of the payroll tax, reflected political opportunities and were not balanced with the cost of package of medical benefits. These premiums were initially considered as the only additional source of health funding. Under the conditions of economic crisis and budget deficit, the real total volume of financing the social services is decreasing. The real public expenditures for health care in 1997 were 79% in comparison with 1991 figures. The annual public funding of health care is insufficient to cover the necessary expenses of the state and municipal medical facilities and to provide medical services guaranteed to the citizens. With the available funds and the unchanged rules of the distribution and use of public funds, this system is only degrading. A tendency to spontaneous and unofficial replacement of free services with paid ones is today increasing. The misbalance has a negative effect on health care. The resources are "spreaded" on the existing network of medical facilities and directed primarily to the salary of the staff. Other expenses are financed partly or are not financed at all. This policy is typical for the states with reducing budget incomes (4). In the situation of underfinancing, the hospitals demand from patients to buy by themselves medicines needed for surgical procedures, including the under-the-table payments to physicians. For example, outpatient clinics demand from patients requiring X-ray examination to bring a film for it. The main reasons for the contradiction between state social guarantees and their public funding are political impossibility to revise the social services guaranteed by the state and weakness of pressure groups in compared to other ones (agricultural and military).

3.5. Inefficient Use of Resources

Compared to other countries, Russia has very high numbers of physicians and hospital beds per 10,000 people. In 1990, Russia had 45 doctors and 138 hospital beds per 10,000 people (15). In the early nineties, the average figures for the established market economies were 25 and 83, respectively (4). The effectiveness of the use of available resources is low.

Table 5. Health Care in Russia from 1985 to 1996

	1985	1990	1991	1992	1993	1994	1995	1996
First time diagnosed illnesses (per 1,000 population)	n.a.	651.2	667.5	615.6	654.3	653.2	678.8	646.8
Death rate (per 1,000 population)	11.3	11.2	11.4	12.2	14.5	15.7	14.9	14.3
Life expectancy (years at birth)	69.3	69.2	69.0	67.9	65.1	64.0	65.0	65.9
Hospital bed numbers (per 1,000 population)	13.5	13.8	13.5	13.1	12.9	12.7	12.6	12.4
Average length of hospital stay (days)	17.0	16.6	16.7	17.0	16.8	18.0	16.8	17.0
Doctors (per 1,000 population)	43.2	45.0	42.6	43.0	43.4	43.3	44.5	45.7
Nurses (per 1,000 population)	122.4	124.5	115.8	115.3	113.1	109.7	110.0	112.7

Source: (15,21)

According to the experts' estimates, inappropriate inpatient cases range from 20 to 35 percent (19). The average length of hospital stay is about 17 days in Russia, and it has been quite stable over the last years (19), whereas in the western countries it varies from 6 to 14 days and these figures have been decreasing (20). The share of inpatient care spending in the total public spending on health care is about 65% in Russia, and it has increased over the last years (19). In the western countries, the situation is opposite. The inpatient care accounts on an average for 40% of the public funds, and this share has decreased due to the introduction of new drugs and new inpatient substitute technologies (19,20). The system of primary health care is ineffective. The therapists in outpatient clinics, who play the role of general practitioners, refer more than 30% of their patients to specialists, in contrast to the practitioners in the western countries who refer only from 4% to 10% of their patients to specialists (19).

According to the calculations of the Ministry of Health Care of Russian Federation, the necessary funding of guaranteed by the state free health care provision might be 93% of health care funding from regional budgets and compulsory health insurance premiums in 1997 if there were more rational use of resources, including the shifts in the structure of medical services provision from inpatient facilities to outpatient ones (Ministerstvo zdravookhraneniya Rossiyskoy Federatsii. Situatsiya v zdravookhraneniye i osnovnye zadachi ego reformirovaniya v 1998 godu. Presented to the Commission of the Government of the Russian Federation for economic reform. Mars 1998. Unpublished data). The funds continued to subsidize the maintenance of a number of existing hospitals beds and physicians who serve them. Moreover, most regional authorities delay the salary for the physicians, but spend a lot of money for the construction of new medical facilities and for expensive medical equipment which is then often underused.

Some administrative bodies in Russia have their own medical facilities which provide health care for their employees. There are structures like military and police, Ministry of the Exterior, Railway Ministry, etc. In the health care sub-division of the 1997 federal budget, the share of the Ministry of Health Care constituted only 66.6%; the share of the President Administration, including President Medical Center, was 10.4%; and the share of other federal authority bodies was 23.1% (Ministerstvo finansov Rossiyskoy Federatsii. Vedomstvennaya struktura raskhodov proyekta federalnogo budzheta na 1997 god. Moscow, 1996. Unpublished data). The so-called "departmental" health care includes 6% of the total hospital beds, 10% of the total medical workers, and about 15% of the public spending on health care(22). In most cases the "departmental" medical services are provided apart from the compulsory health insurance, and the "departmental" medical facilities duplicate the

ordinary ones. The maintenance of "departmental" health care is a heavy additional load on the budget.

3.6. Underdeveloped Public Control over the Use of Public Funds

Ineffective, and disagreeable with the present socio-economic reality, the use of the public funds continues due to the absence of effective control over the budget allocation spending. The implementation of reform has also revealed the problem of weak public control over the compulsory health insurance funds and activity of the health insurance carriers. The forms of control provided by law are most underdeveloped in Russia compared to other countries with health insurance system.

4. New Priorities of the Reform

Continuation of the reform is needed to solve these problems and to terminate degradation of medical services provision. In 1996-1997, the situation with public financing severely deteriorated. The budget crisis indicated the necessity to continue health care reform. In November 1997, the federal government adopted The Concept of Development of Health Care and Medical Science in the Russian Federation (23). According to this document, the main directions for the necessary actions are following:

4.1. Balancing the Financial Flows and the State's Obligations

To deal with this task, either health care funding should be increased by the redistribution of resources in its favor or the efficiency of public expenses should be sharply increased or the state's obligation revised.

The government has not attempted to revise the state guarantees. However, they will be specified in the federal package of free medical services. According to the governmental Concept, the federal program of public guarantees of medical services delivery should be adopted every year. The program determines the range and volume of free medical services and standards of their public funding. The basic (national) program of compulsory health insurance is a part of the federal program of public guarantees. The draft of the Federal program for 1998 does not expect the increase of public funding of health care and proposes stimulation of the structural shifts in medical services from too expensive inpatient treatments to outpatient treatments and introduction of inpatient substitute technologies. This is assumed to increase the allocative efficiency and to balance federal package with public funding.

This proposal has two main obstacles: a) the desirable structural changes can be very slow; and b) the state budget will be still unbalanced, and the planned expenditures will not be fully financed as it was in the previous years.

Taking this into account, preservation of the gap between public guarantees in health care and their public funding should be expected. However, this gap will be reduced if the policy of specification of public guarantees is followed consecutively. Nevertheless, the public guarantees should be fundamentally revised in future. This means: a) revision of the conditions and scale of providing medical services to population for free or on a preference basis; and b) reduction of the social services list and its differentiation in accordance with income and age strata of population. The most acceptable variant of such revision is the introduction of the co-payments by the patients for some medical services. The low-income population group should still receive medical services on a free basis or the compensation payments from the state budget. Reducing the scope of free or subsidized services and revising the range of their recipients would be a radical and extremely unpopular measure. Viewed as a pure financial measure and introduced separately, without revising the other state policy components could entail undesirable social and economic consequences on a large scale. If the financial standards established by the state are not observed, if there is no efficient control over

the use of allocated money, if there are no effective mechanisms protecting the citizens' rights (both those who will now pay for the services, and those who will continue to obtain them free of charge), this measure will only reproduce the old problems on a new level, increasing social discontent. However, if the government proves that it is determined to fight against the abuses, if it establishes and ensures observance of strict rules in providing social services, if the least protected population groups do not lose but gain from an improvement in the quality of the services provided specifically for them, then the changes in terms of financing the medical services will be accepted by the public and would improve the situation in health care.

4.2. Overcoming the Fragmentariness of Health Insurance

Health insurance is considered a basic system of health care financing. The task is to make sure that the introduction of compulsory health insurance ceases to be so inconsistent and fragmentary: the budget must unfailingly transfer to the health insurance funds for non-active population. Then the insurance funds and insurance carriers will become the main purchasers of medical services in all regions. The problem is how to force regional and local authorities to completely transfer payments for non-active population into regional compulsory health insurance funds. Because of political weakness, the federal government cannot implement this administrative power. In these conditions, it has been proposed to change the order of the existing transfers from federal budget to regional budgets, separating a targeted part of health care from such budget transfers. The region could receive the transfer under condition that it transfers its part of premiums to the regional compulsory health insurance funds. The funds from the federal budget are transferred directly to the regional compulsory health insurance funds. Thus the premiums for non-active population are paid from the federal budget on a par with regional budgets. The government has specified the targeted transfers to regional compulsory health insurance funds in the project of federal budget for 1998. The planned ratio of transfers from federal and regional budgets has been on an average 1 to 2.25. However, the Parliament has not approved such innovation in the federal budget for 1998 because the regional elite prefers to receive the transfers from federal budget without any additional restrictions. The possible way to solve the problem of incompleteness of health insurance implementation has been discussed in the government.

Consolidation of Compulsory Health Insurance Funds with Social Insurance Funds is considered a possible way to increase the efficiency of the whole system of social insurance. The consolidation may create incentives to insurers in the decrease of morbidity, rational allocation of recourses into preventive measures, treatment and rehabilitation.

4.3. Preservation of Private Insurance Carriers as the Agents in Compulsory Health Insurance System

The governmental concept considers the scheme of medical services' financing by the competing insurance carriers as the basic one. The scheme with a regional compulsory health insurance funds, acting as insurers, is implemented for financing the medical services provision in thinly populated areas where the activity of private insurance carriers is difficult.

The role of private insurance carriers in compulsory health insurance is still under discussion. There is an intention to introduce the system of state accreditation of health insurance carriers in order to avoid passive translators of public funds to medical facilities. This approach has been already approved in Moscow and in Khanty-Mansiysk region. In December 1996, only 8 out of 25 insurance carriers were accredited as the actors of Moscow compulsory health insurance system (8). They legally divided the areas of activity in Moscow. Only 4 out of 15 carriers were accredited as compulsory health insurers in Khanty-Mansiysk region in September of 1997 (24). This implies the introduction of the administrative evaluation of efficiency of private insurance carriers and the selection of more effective or more reliable ones from the administrative point of view. The Federal Compulsory Health Insurance Fund insists on the introduction of similar accreditation all over the

country. The possible negative results are evident. This approach can lead to elimination of all possibilities for purchaser competition. The administrative selection of private insurance carriers will most probably cause the strengthening of clans realizing their special interests to the detriment of public ones. The insurance carriers acting in compulsory health insurance system should naturally meet some special requirements. These requirements should be defined by law as clear criteria for licensing to act in compulsory health insurance system, and as clear conditions of deprivation of the license.

It should be mentioned, however, that real competition among insurers and among providers will be hardly probable in the near future, and even the institutional obstacles for it will be removed. In this connection, the appeared pulling back from reliance on competitive incentives as the driving force for health sector reform in Sweden and United Kingdom deserves greater attention (25,26).

The role of insurance carriers should be considered first of all in the development of the economic approach to health care provision. They are potentially more effective in this role than the health administrative bodies, and the state insurance funds inherited the bureaucratic traditions of health care administration.

The rational strategy of reform is to encourage competition among purchasers and among providers in those regions where the elements of competition already exist or can be created. It should not step back, initiating or stimulating the limitation of insurance carriers operating in compulsory health insurance system. On the contrary, in those regions where the insurance carriers do not operate, there is no sense to oblige the insurance funds to deal with insurance carriers as a mediators between insurance funds and medical facilities, and thus to encourage the emergence of insurance carriers in these territories. Such policy minimizes the risks of inappropriate institutional transformations and gives the opportunity to make a right choice on the following stages of the transition.

4.4. Development of Planning on Federal, Regional, and Municipal Levels

The introduction of common approaches to planning, standardization, and licensing is considered in the governmental Concept as the main procedure in the integration of health care management system. The federal target programs for health care development and the federal program of public guarantees of medical services delivery should be the base for health care planning. The corresponding regional and municipal health care programs should be elaborated.

There is a need for a coordination among federal, regional, and local health authorities, and federal and regional compulsory health insurance fund policies. The new organizational and legal mechanisms of interaction among the authority bodies at different levels and compulsory health insurance funds should be introduced to resolve the problems of ineffective health care funds allocation.

4.5. Assurance of the Transparency of Financing System

The real problem of the Russian reform is the emergence of pseudo-market in health care with predominance of monopolies and clan-type links, without effective regulation of quality of medical services and without effective financial control of medical facilities, insurance funds, and insurance carriers. To avoid this, the attention should be concentrated on the development of democratic procedures of administration and control in health care, on ensuring the transparency of the financial flows and organizations using public funds.

4.6. Integration of "Departmental" Health Care into the Regional Health Care Systems

It is necessary to reduce the scope of "departmental" health care. The medical facilities under different federal authority bodies should be transferred to the regional authorities and financed by

compulsory and voluntary health insurance or regional budgets. This allows the rationalization of the network of medical facilities and the allocation of public funding, and the increase in the equity of health care provision.

4.7. Structural Transformations in Health Care Provision

The strengthening of the role of primary health care is considered the main direction in the improvement of the medical services provision. The part of the resources of health care provision should be shifted from inpatient to outpatient care. Much attention will be given to the emerging of the general practitioners who should gradually substitute the therapists working in outpatient clinics. The consulting and diagnostic services, departments for medical and social rehabilitation, and day-clinics will be established on the basis of the existing outpatient clinics.

The reorganization of inpatient care should ensure the decrease in the length of hospital stay. This means the rationalization of the structure of hospitals' beds, development of specialization among the hospitals, transformation of the hospitals' capacity into one-day clinics, etc.

4.8. Development of Private Sector

The creation of the legal basis for the emergence of private sector is considered an important element of necessary structural transformations in health care. The bill "On Private Medical Activity" is being elaborated in the State Duma. Unfortunately, it has a lot of opponents among the deputies. The prospective direction in the institutional transformation of health care provision is "non-profit privatization". This means the transformation of state and municipal medical facilities into non-state or quasi-public non-profit organizations.

The physicians and other citizens, and/or legal persons, as well as the government bodies, might act as cofounders of such organizations. It is a promising approach to create more flexible facilities for medical services provision, as well as to find new sources health care financing.

The model of non-profit privatization may be considered a prospective solution of the problem of running the medical facilities owned by privatized industrial enterprises. Instead of total municipalization of such facilities, as the state is short of funds to accomplish this, it makes sense to transform them into non-profit organizations. The municipal authorities and the companies, formerly owning them, are cofounders of such organizations. In this case, the local budget and enterprises will share the burden of running the respective institutions.

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