www.iet.ru

Sergei V. Shishkin

METAMORPHOSES OF THE RUSSIAN HEALTH CARE REFORM

Voprosy economiki, 1995, N 9, pp. 26-33

Transformation of the Russian health care financing and organization systems has been realized since 1988. Throughout this period the policy carried out by the state has undergone a number of metamorphoses.

At first, it was suggested to regulate the budgetary financing of health care and to extend the rights of medical institutions in solving economic problems. Later on, in 1991 the policy of radical replacement of the budgetary health care system by insurance medicine system was proclaimed. In 1993 a significant correction of the selected compulsory medical insurance model took place. In 1993 - 1994 a new model of health care financing and organization started to be introduced in all the regions but with different success. The first results of transformations have become an object for acute discussions and polar assessments. Since late 1994 the control bodies of the branch both in the Center and in the regions started to demand for radical revision of the introduced model. The core of their attitude was a restoration of the budgetary health care financing system in a new form and in combination with the voluntary medical insurance system. So, the process of insurance medicine introduction has slipped. What was the reason for that? And how can we explain all these metamorphoses of the reform?

The start of the reform: transformations within the framework of the budgetary health care system

The health care reform has started within the framework of the Soviet economy general "restructuring". However, it has been initiated not by the leaders of the country but by the control bodies of the branch. The reform has reflected the interests of medical community as a whole, but primarily - interests of health care bodies in the center and in the province. The reform hasn't changed the basic principles of budgetary health care system. A new model of budgetary medicine ("new economic mechanism in the field of health care") has been proposed. This model stipulated:

- allocation of budgetary resources to health care according to long-term stable norms per one resident;
- changes in the order of budgetary financing of health care institutions, transition from allocation of resources by separate items of expenses (for salaries, for economic needs, for equipment, etc.) to financing according to stable long-term norms reflecting results of their activities;
- introduction of the system of economic settlement among in-patient and out-patient institutions for diagnosis and treatment in hospitals;
- permission granted to the health care institutions to sign contracts with various companies for medical servicing of their workers, to render additional paid services to the population besides the free medical assistance norms;
- granting to the heads of the health care institutions a certain independence in the fields of labor remuneration and organization.

The model has provided budgetary financing stability and extended opportunities for medical functionaries to be in charge of state-owned resources and to collect rents on the basis of their position. The heads of the health care

institutions have received right to use state-owned property for commercial activities and to receive profits quite legally. The reform has improved the situation with labor remuneration for persons involved in medicine: it started to be possible to set the volume of salaries depending on the quality and quantity of the work.

In 1988 the new model of budgetary medicine was as an experiment introduced in the city of Leningrad, Kemerovo and Kuybyshev oblasts (regions). Since 1989 this system started to be introduced in 9 other regions. However, the problem was in the fact that transition to the new budgetary financing order (on the basis of stable norms) was rather formal. Financial bodies prolonged elaboration and adoption of such norms or failed to observe them.

Adoption of the regulations on medical insurance

On the verge of 90s the state budgetary resources started to decrease, the struggle for "dividing the budgetary pie" became harder. In order to defend their vested interests, the bodies controlling health care started to demand for more radical reforming of health care financing and organization systems. They selected the introduction of medical insurance. The latter was supposed to solve the problems of increasing sources and volumes of the health care financing. Ideological factors also produced a significant impact upon this selection. Ideas on necessity of the introduction of radical economic reform, decisive transition to market economy were also affecting the field of health care. Medical insurance was considered as a health care system maximum conforming to the market economy, as a means to create market environment for medical institutions, to improve medical service quality and more efficient use of resources.

In June 1991 the law "On Medical Insurance of the Citizens of the Russian Federation" was adopted. The changes concerning health care financing were as follows:

- the enterprises transfer insurance premiums for compulsory medical insurance of active population; the premiums have tax character;
- insurance premiums for compulsory medical insurance of non-active population are paid by the state control bodies at the expense of budgetary resources;
- the volume and conditions of free medical assistance within the framework of compulsory medical insurance (CMI) are defined in the base CMI program confirmed by the government, and in regional CMI programs adopted by regional authorities and conforming to the base program; the volume of insurance premiums are established in accordance with the adopted CMI programs;
- besides compulsory insurance, voluntary insurance at the expense of resources belonging to enterprises and private resources of the population can also take place.

It should be noted that, in fact, the new system of public financing of the health care reproduces in a new form and develops the same financing system that was stipulated by the "new economic mechanism" model. The norms of budgetary financing have transformed to budgetary insurance premiums at fixed rates. The idea on the introduction of free medical assistance norms has transformed into the idea of the base CHI program. The right to sign contracts for services besides the above-mentioned norms granted to health care institutions and all interested organizations was developed in the voluntary medical insurance. In addition to the budgetary medicine model, the CMI model was provided with a new source of guaranteed proceeds to health care - the payments of enterprises for compulsory health insurance.

The changes in health care financing order continued the previous attempts to transform financial flows to the branch. However, as to organization of financial

flows within the branch, the insurance health model stipulated radical innovations. New entities - private insurance medical agencies appear within the framework of the health care system. The enterprises and state control bodies which act as insurers, must sign contracts with insurance agencies which, in their turn, select medical institutions and pay for preventive and general treatment rendered to the insured persons.

The new model stipulates that new financial institutions should appear within the framework of the branch. These institutions should accumulate budgetary and non-budgetary resources and should have a legal right to effect transactions involving these resources. A great variety of new possibilities to collect rents from their position is opened for those functionaries who determine conditions of the budgetary resources transfer to medical insurance agencies, control accreditation of medical institutions, set prices for medical services, establish the order of settlement with medical institutions, etc. We could suppose that the realization of such possibilities played a significant additional role in reformatory activities of the heads of the health care branch in the center and in some of the regions.

In 1991, after dissolution of the Soviet Union the governmental management of the social services provision and of the health care in particular was decentralized. Regional health care administrative bodies became not administratively subjected to the federal ministry of health care. The ministry directly administeres only the medical institutions which are in federal property, and carries out certain controlling functions, and establishes federal requirements to state licensing and attestation procedures of medical institutions, etc. Regional authorities administer medical institutions which are under their property rights; local authorities administer municipal hospitals and out-patient clinics. Lower executive bodies dependency on the higher ones remains only where the latter possess and can distribute the means besides the finance of the institutions which are under their property rights.

The decentralisation had a great influence on the health care reform. Federal bodies care could not already use the administrative methods for introduction of compulsory medical insurance. Meanwhile the rights and the responsibilities of federal and regional authorities for the implementation of the reform were not clearly defined in legislation. The process of creation of medical insurance infrastructure became depending in great mesure on the position of regional authorities.

Initially it was planned to complete transition to medical insurance system in 1992 - 1993. Subsequently the term of compulsory medical insurance introduction was shifted to 1994. While preparing the introduction of compulsory medical insurance everywhere, the introduced model underwent substantial adjustment. According to the law on medical insurance adopted in 1991, the functions of insurers should be implemented by health insurance agencies which are independent from the health care administrative bodies and medical institutions. It was not planned to create any special agencies for collecting and accumulation of CMI premiums. In 1993 the law was appended by the regulations on creation of such agencies: the Federal and regional Funds for compulsory medical insurance. The regional CMI Funds were granted with the rights not only to sign contracts with health insurance agencies but to act as insurers and to have direct interrelations with medical institutions. It should be noted that the CMI Funds were exempted from tax on general activity profits, and the insurance agencies were not.

These changes in the CMI model were caused by the fact that the process of creating medical insurance agencies and their integration to the CMI system was slow and erratic. Medical insurance agencies were intensively created and

deployed their activities in those places where regional authorities actively supported and introduced the new health care model. However, these regions constituted minority. The largest part of the governors and of the heads of regional health care bodies supported the introduction of CMI 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. Creation of the CMI Funds acting as state institutions was more acceptable to them.

The legislation defined the CMI Funds as independent, state, non-commercial, credit and financial institutions. Their boards of managers include people's deputies, representatives of regional administration, medical associations, trade unions, etc. The Funds are accountable to the regional administration and representative power bodies, but they are not subordinate to the health care state bodies in administrative respect.

Creation of the CMI Funds signified that new entities have appeared in the health care system. These entities finance not only medical insurance companies but medical institutions directly. That's why the Funds have acquired the opportunities to control and supervise their activities. The resources of the Funds were supposed to be used for financing medical assistance rendered to the population, i.e. for the services rendered by medical institutions within the framework of CMI programs.

The CMI Funds and their local subsidiaries did not substitute the regional and local administrative bodies. The latter saved the function of administration of the medical institutions wich are under their property rights. The regional health care bodies still finance the material and engineering base of health care, training of the personnel, activities of specialized medical institutions (TB dispensaries, psychiatric hospitals, etc.), arrangements preventing epidemics and other arrangements having the character of public wealth. The sources for that are the budgetary allocations for compulsory insurance of non-active population besides insurance premiums.

However, the federal legislation didn't make a clear distinction of functions and power between the state health care bodies and the CMI finds. The scope of activity and field of responsibility of the CMI Funds became derivative from the contents of regional CHI programs. Therefore, the distribution of power between the health care bodies and the CMI Funds should be determined at the confirmation of these programs. So the adoption of decisions on rights and responsibility redistribution between old and new entities within the health care system was delegated to regional authorities.

Introduction of compulsory medical insurance system

Since the second half of 1993 the enterprises and institutions were obliged to transfer insurance premiums for medical insurance of their workers equal 3.6% of their payroll funds. These resources started to be accumulated on the accounts of regional CMI Funds (3.4%) and federal CMI Fund (0.2%). By early 1994 82 regional CHI Funds and more than 900 subsidiaries were created. 294 insurance companies were included into the CMI system. The year of 1994 became a year of official introduction of the compulsory medical insurance system all over the country. The reform reached its peak.

While preparing the introduction of CMI the Health Care Ministry was transformed into the Ministry of Health Care and Medical Industry. It was headed by the newcomers who had previously worked in the field of military health care.

The heads of the Ministry struggled for introduction of compulsory deductions made by the enterprises for medical insurance, but they made no efforts in order to reform the system of interrelations within the framework of the branch. The reform was created not by them but by other people. Moreover, an idea of insurance medicine was probably alien to their views and experience formed under specific conditions of military medicine. After the Ministry managed to introduce premiums for CMI it practically halted the work in the field of developing the legal and regulatory basis of CMI. The control over the reform was neglected, and the reform was decentralized.

Substantial regional differences in the pace and deepness of transformations were revealed immediately. According to the RF Ministry of Health Care and Medical Industry data, in 18% of the regions only in-patient treatment was financed from the CMI Funds in 1994. On the contrary, in some other regions only out-patient treatment was financed. In october 1995 only 56% of the Russian population were provided with insurance policies.

In 1994, according to the Federal CMI Fund data, in 20 regions (of 89 which are the subjects of the Federation) the insurance agencies have really become intermediaries between insurers and medical institutions in the process of the CMI program implementation. In other regions the functions of insurance were fully or partially executed by the regional CMI Funds themselves or their subsidiaries. Only in 40 regions the budgetary resources were transferred to the CMI Funds as the premiums for non-active population. However, they were transferred not in full volume. According to the State Committee for Statistics data, the budgetary payments for insurance of non-active population transferred to the CMI Funds constituted 31% of the insurance premiums paid by the enterprises in 1994. By the way, the number of non-active population amounts to 108% of the number of employed.

During 1994-1995 the base model of medical insurance has not been introduced in full in any region. The eclectic combination of the elements of state financig system and insurance finansing system has taken place instead of consecutive transition from one system to another. The mixed picture of regional "models" of such combination still exists.

There is one important reason for this diversity beside the decentralisation of the reform and lack of central control on its implementation. The revenues accumulated by CMI Funds are not sufficient to cover the gap between fund available and those required to provide free medical services garanted to people by government. This is the reason why it has been impossible to change in full the old system of administarative distribution of means between hospitals and out-patients clinics by new system of finance medical providers on fee-for-service or on capitation base. The region must balance the CMI finance with the amount of health care providers and the set of medical services financed from CMI Funds. Each region has established such balance on its own way.

In majority of regions all budgetary resources or a part of them were still at the disposal of the health care bodies. As to the resources accumulated in the CMI Funds, they were used in order to purchase medicines, medical equipment, sanitary transport and were an additional source for financing labor remuneration of medical workers. To put it differently, the distribution of functions between the health care bodies and the CMI Funds turned to be reverse with respect to the situation planned by the CMI model.

After the introduction of CMI the regional and local authorities immediately started to reduce expenses for health care from the regional and local budgets substantiating this by the fact that the branch had acquired a new financing source. In 1993 the share of above-mentioned costs amounted to 17.5% of the general expenses in the regional and local budgets. In 1994 it amounted to 15.7%

and in 1995 to 15.3%. The corresponding share of expenses in the federal budget decreased from 1.7% in 1993 down to 1.6% in 1994 and down to 1.3% in 1995. In 1994 the volume of state budgetary financing of health care in comparable assessment reduced by 19.7%, and in 1995 the decrease was by 26.8% in comparison with 1994 data. The expectations of the medical workers that the insurance proceeds from legal entities would become an additional source of money besides direct budgetary financing failed.

In 1994 the compulsory insurance premiums of the enterprises constituted 0.7% of GDP or 17.6% of the public financing of the health care. In 1995, according the data for nine months, these chares were 0.6% and 18.9% correspondingly. In 1994 the public financing of health care (including budget financing and compulsory insurance premiums of enterprises) has reduced in comparable assessment only by 2% in comparison with the volume of budget financing of health care in 1993, while GDP has reduced by 15%. The situation in health care financing is much better than the situation in the state financing of other social services. For example the public financing of education has reduced by 14% throughout the same year. So the introduction of compulsory health insurance has allowed to stabilize financing of health care under conditions of continued economic crisis.

However, the key issue for the destiny of reforms was the reduction of resources which were at direct disposal of medical functionaries. In 1994 the allocations for health care from the local budgets (with the exception of resources transferred to the CMI Funds in the form of insurance premiums for non-active population) constituted 74% (in comparable assessment) of the volume of health care financing from the local budgets in 1993. A part of financial flows avoided the health care bodies and passed through the CMI Funds and insurance agencies. In 1994 the resources accumulated by the regional CMI Funds were equal 35% of the volume of expenses for health care in the local budgets.

The problems created by the reform

As a result of the changes in financial flows the position of the state health care control bodies has also changed. The opportunities for the functionaries based on the volume of the resources controlled by them have substantially reduced. The officers of the health care bodies could no longer give direct instructions to the CMI Funds how to spend the accumulated resources. However, the creation of new financial institutions within the branch has shown the functionaries new non-traditional ways how to collected rents from their position. Nevertheless, the majority of the regional health care bodies heads, probably, have failed to use their chances. We can suppose that not medical functionaries but deputy heads of the local administration became the main rent-collectors from the CMI Funds. As a rule, these deputy heads are chairmen of the Funds' boards. Besides, mastering new methods of getting illegal profits is time-consuming. As to reduction of traditional opportunities, it occurred at once. The weakening of power of the health care bodies hasn't been adequately compensated.

While implementing the reform, the group of special interests tried to redistribute public resources in their own favor by changing the rules of receiving such resources from society. However, starting the game according to the new rules, the most of medical functionaries have lost. Besides, in course of the large-scale introduction of CMI a great number of collisions have emerged due to poor elaboration of its legal and regulatory basis.

The diversified system of substantiated and detailed norms of costs for different medical services within the framework of CMI hasn't been created. These norms should represent medical standards for clinical and statistical groups of

diseases, reflect requirements to the volume and quality of medical assistance and be the basis of tariffs for medical services. This fact has created conflicts between the health care institutions and the CMI Funds and insurance agencies in the field of paying for the services.

The system of inter-regional settlements for the services within the framework of CMI hasn't been elaborated in due time. As a result the people were deprived of free medical assistance beyond the limits of the region they live in. Specialized medical institutions created and working as inter-regional centers were forced to deprive the residents of other regions of medical aid, as these centers were financed from the budgets of those regions they were located in.

In those places where financial resources are accumulated there is a possibility to use them not only for medical assistance rendered to the population but for individual profit of those who work in the Funds and insurance agencies. One of the main ways to improve the legislation on insurance medicine is to reduce such possibilities. Legal and financial independence of the regional CMI Funds shouldn't mean lack of control over their activities from the authorities and the public. Nevertheless, the scope of responsibility and power of the CMI Funds hasn't been clearly determined neither by the federal nor by the local authorities.

Being the independent financial institutions, the Funds have their own economic interests. It is profitable for them not to spend arriving premiums immediately, but to have more money as free balance which could be used for commercial transactions and could increase their assets and incomes of their employees. As a rule, the regional CMI programs contained many general aspects and failed to determine clearly and unambiguously the fields for spending of the resources accumulated in the Funds. The framework within which the Funds' executive boards have received opportunities to adopt independent decisions has turned to be rather wide.

Thus, the Funds' policy contradicted the perception of medical workers on expedient fields for using the CMI resources. In the middle of 1994, for instance, only 70% of resources accumulated by the Funds in the average were spent for financing health care proper. The rest 30% were kept on banks accounts and were used for commercial transactions. However, in the second half of 1994 this share substantially reduced. In late 1994 the resources placed as deposits and the balance on deposits amounted to 15% of the total proceeds throughout the year. The interest on deposits increased these resources by 4.4%. The sums allocated by the Funds for financing the regional health care programs and other arrangements constituted 96.0% of insurance premiums paid by the enterprises and budgetary payments for insurance of non-active population.

In the opinion of the medical functionaries such use of the CMI resources is not justified. They also criticized substantial expenses for buying PCs, cars, as well as expenses for the upkeep of the Funds' administration. In 1994 the latter amounted to 3.2% of the Funds' total expenses. As a rule, conditions of payment and labor in the Funds and in the medical insurance agencies turned out to be better than the ones in the health care bodies. And naturally, this caused the irritation.

The functions of management, control over the current activities of the Funds haven't been clearly determined and adjusted. The interrelation between the executive directors of the Fund and the chairman of the Fund's board plays a crucial role in Fond's policy. Some of the head of regional health care bodies has been the chairman of the Fund's boards. As a rule the conflicts between the the medical functionaries and the CMI Funds have not taken the sharp forms in such region. But in most cases the heads of the health care bodies were the ordinary members of the Fund's boards and lacked adequate powers to control the spending by the CMI Funds. We can suppose that executive directors of the Funds

had non-formal agreements with the chairmen of the boards concerning the order of the use of the Funds' resources. Probably, as a rule, the heads of the health care bodies were left beyond the process of these administrative bargains.

As a result of these transformations the elements of dual power have appeared in the management of the health care system. A conflict of interests has arisen between the new entities and the health care bodies. It was reinforced by the claims from the Federal CMI Fund to consolidate CMI Funds into an integrated system. That could mean creation of a vertical health care management structure parallel to the existing one.

In case the reform continues in the form it was initially planned, the medical functionaries will face more losses. So the attitude of the health care management bodies towards the introduction of CMI has changed.

Before the large-scale introduction of compulsory medical insurance a substantial part of medical workers regarded it with great precaution. Those were some physicians and heads of medical institutions who had low qualification and psychologically were not ready to play according to the new rules. So they didn't want to risk their position and their stable salaries (though low in comparison with other industries), as well as their opportunities to receive illegal incomes. In the process of the implementation of the reform the negative attitude of this part of medical workers became stronger. For majority of them the reform didn't give any additional earnings but gave extra responsibility. The physicians had to fill in more documents, the heads had to adopt themselves to the new procedures and conditions for earning money.

To be continued?

Since the second half of 1994 most of the regional health care bodies supported by the workers of the medical institutions started to demand for the right to control the spending of resources received by the CMI Funds. In a number of regions they have forced the regional athorities to adopt such decisions. For instance, it was done in Bryansk and in Kemerovo oblasts in early 1995. It should be noted that these regions were among the initiators and leaders of insurance medicine introduction.

However, in some of the regions the state bodies did not change their positive attitude towards the reform. Still it is interesting to note that the introduction of the insurance medicine is supported in those regions where the financial situation is better and so the volume of budgetary financing of health care hasn't reduced. For instance, in Samara oblast which intends to go even further along the way of health care reforming, the volume of budgetary allocations in 1994 was not less than in 1991 (in comparable assessment). Moreover, 20% of resources transferred by legal entities to compulsory medical insurance and 10% received for paid medical services were added.

The heads of the medical branch were negative towards the transformations which had been carried out. In the beginning of 1995 the Ministry of Health Care and Medical Industry of the RF prepared a draft project for reforming compulsory medical insurance. The new model stipulates that CMI will be supported by the state system of medical insurance. The functions of insurers will be executed by the health care bodies. The Federal and regional CMI Funds will be transformed into institutions founded correspondingly by the Ministry of Health Care and Medical Industry of the RF and the regional health care bodies. The Funds shall be subordinate to them. For medical insurance agencies only the functions of voluntary medical insurance will be left.

The adoption of such a model would mean restoration of the system of administrative control over health care which existed previously. But the

traditional activities of the health care bodies would be called differently: "provision of compulsory medical insurance". Besides budgetary allocations for health care the contents of CMI would be reduced to compulsory insurance premiums collected from legal (and maybe from natural) persons. Besides, a new financial and credit institution would appear under the authority of the health care bodies. This institution could be merely used for extracting profits in favor of medical functionaries.

The draft did not passed. The State Duma has prevented revision of the introduced CMI model and restoration of the state-run health care system. But the reform was stopped practically in all regions. Since the middle of 1995 the attacks on the CMI Funds and on the medical insurance companies were weakened. We can suppose that the CMI Funds began to chare their revenues with the medical functioners to a more considerable extent. Meanwhile the situation is unstable.

Continuation of the reform now suits the interests of CMI Funds and medical insurance companies. However, they can't succeed in full-scale introduction of the CMI system in all the regions in near future. It is impossible to impose the introduction of the reform to the people who are no longer interested in it. One can change the attitude of the majority of medical workers and managers to insurance medicine only when more resources are sent to the health care branch. And this will become real only after the country goes out of the economic crisis. Then it will be possible to continue the large-scale health care reform with great chances to succeed.

The Ministry of Health Care and Medical Industry has not refused the intention to revise the CMI model. Such attempt may be more succesfull under the new composition of The State Duma after the election in December of 1995. However it is highly unlikely that medical funcioners will manage to win and place under control the CMI funds in all the regions. For example, a number of the regional CMI funds and insurance companies--Moscow, St.Petersburg and Samara--possess probably sufficient influence needed to protect their interests in the parliament. In case the counterreform amendments to the law on medical insurance are adopted, they will impose their wording of the document which will give them free hand in their regions.

From the point of fiew of public interests it is important at least in some of the regions to continue the work on developing and improving the legal and regulatory basis for interrelations among all medical insurance entities, including clear distribution of rights and powers among the regional executive authorities and the regional compulsory medical insurance Funds. As this will take place, it is acceptable and expedient to adjust various modifications of the source model. Under conditions of great regional variety existing in our country the use of different versions of the health care system organization and of the "transitional models" from the budgetary health care system to medical insurance is quite justified. Unequal pace of health care system's transformation in different regions is a reality of the transition period that will be preserved in near future.