Problems of Transition from Tax-Based System of Health Care Finance to Mandatory Health Insurance Model in Russia

Sergey Shishkin
Institute for Economy in Transition, Moscow, Russia

This article examines three problems burdening the Russian system of health care finance in transition period: (a) unrealistic government promise to cover health care coverage too wide to be achieved with available resources; (b) inefficient management of health care delivery systems; and (c) lack in evidence of actual positive changes effected by the new players: mandatory health insurance carriers and funds. Radical reshaping of the health benefits promised by the government and introduction of patient co-payments are considered as a way to normalize public health sector finance and operations. Two alternative approaches to the reform of the existing eclectic system of health care management are available. Institutional preconditions for operational effectiveness of third-party purchasers of health services in public-financed health sector are defined.

Key words: health care; health expenditures; health insurance; health plan implementation; hospital costs; insurance, health; planning, health and welfare; management information systems; resource allocation reform; Russia

The transition from a socialist model to market-driven economy in Russia includes an attempt to replace the former tax-based system of health care finance with a mandatory health insurance model. The reform, however, was hindered by the complexity of the proposed mandatory health insurance system, its incomplete implementation, eclectic combination of old and new financial arrangements, wide cross-regional variations in transitional models, poor coordination of actions and delineation of authorities between players in the field of health care finance, and failure to induce due competition between health insurance carriers (1,2).

Currently, the national system of health care financing is characterized by three main problems: (a) unrealistic government promise of health coverage too wide to be achieved with available resources; (b) inefficient management of health care delivery systems; and (c) lacking evidence of actual positive changes effected by the new players, mandatory health insurance carriers and funds. Further evolution of the national system of health care finance, including mandatory health insurance system, will depend on how these problems are addressed and resolved. The intent of this paper is to analyze those problems and suggest some solutions.

Financial Inadequacy of the Government Promise of Free Health Care

Compared to 1991, public health expenditure in 1998 fell by 33% in terms of resource-related value (3-6). At the same time, the government promise of free health services was ever the same. Financial collapse in August 1998 produced a dramatic negative impact upon the entire health care sector. Public funding of health care (including government allocations and mandatory health insurance premiums collected from employers) was 18.5% lower in 1998 than in 1997. The Ministry of Health of the Russian Federation reported the projected annual cost of primary and secondary care, with current utilization patterns in place, to be equal to 3.8% of GDP in 1998. This estimate was rated with standard costs per outpatient visit and per bed hospital day. The rates would include neither all existing facility network maintenance nor costs of new equipment. Moreover, no adjustments were made to reflect excessive operational costs capacities existing nationwide. Therefore, the projected annual budget could not cover actual costs incurred within the current national system of health care delivery unless it is restructured and optimized.

Costs of primary and secondary health services should be covered with allocations by regional governments and employer contributions to mandatory health insurance funds. In 1998, actual public health expenditure (aggregate of regional allocations and mandatory health insurance premiums collections) equaled 2.9% of GDP (3,4). However, only 75% of projected health care costs could be covered with those resources Considering this inadequacy of pricing methodologies used to project costs, it is obvious that the actual level of deficiency of public health programs was much higher (Table 1).
In 1998, the federal government took the first major step to review its promise of universal health coverage. In November 1998, the "Program of Government Guarantees of Free Health Services Delivery to Citizens of the Russian Federation" was approved. While leaving the benefit schedule unchanged, the Program contains useful tools to balance available resources with government guarantees of free health care through meticulous restructuring of current health care utilization patterns to replace costly hospital care with inexpensive outpatient services wherever possible. The trend to reduce excessive hospital capacities was already visible in the past decade (Table 2). The Program instructs local health care executives to enforce further close-down of idling hospital facilities that fail to demonstrate high cost-effectiveness of care. The Program sets the target of 18.5% reduction in hospital utilization through shifting as much service as possible to the outpatient sector (e.g., hospital or polyclinic day-care facilities). The share of outpatient costs in public health expenditure will increase from present 27% to 35-40% in the future. With these targets achieved, public health care expenditure required to cover the costs of government guarantees will mount to 3.05% in 1999, which is about 75% of what would be required to fund public health sector with present utilization patterns in place.

Unfortunately, neither definite timeframes to achieve the Program targets nor cost-analysis of restructuring activities are offered in the document. To implement the Program, trilateral agreements are concluded between the Ministry of Health, Federal Mandatory Health Insurance Fund, and health authorities at each of the subjects of Russian Federation. Such agreements cover the following issues: federal government obligations to fund targeted federal programs (e.g., diabetes mellitus, tuberculosis prevention, immunization, medical technologies development, and other public health projects sponsored by the federal government); Federal Mandatory Health Insurance Fund obligations to subsidize territorial health systems; and local governments’ obligations to adopt and execute territorial program of health benefits in compliance with the federal program and restructure their respective health systems.

Adoption of the federal program and matching territorial programs of health benefits, however, may not resolve the problem of financial shortfall in the health sector, as it will not address the key issue of excessive coverage promise. The most optimistic projections for 1999 estimate that 2.8% of GDP for health care expenditure available from regional budgets and employer contributions to mandatory health insurance funds, which is only 92% of what is required to cover costs of health care programs. Therefore, health sector financing and operations will not be normalized, unless steps are taken to radically reshape health benefits promised by the government. The most handy solution is to introduce patient co-payments, while leaving health services absolutely free for low-income categories and patients with certain diseases.

Deficient public funding of health services has already resulted in widespread practices of unauthorized co-payments. A survey of families in 14 regions in January 1998 (conducted by the Institute for Sociological Study and sponsored by the Boston University Project of Legal and Regulatory Reform in Health Sector) estimated out-of-pocket payments for health services and drugs at no less than 2.69% of GDP Out of this amount, 1.5% went for over-the-counter drugs, whereas the remaining 1.2% where costs of direct provider reimbursement (7,8). The share of shadow "pocket-to-pocket" payments (0.3% of GDP) was far less than the share of multiple odd arrangements invented by administrators of health care facilities to collect unauthorized co-payments from their patients right in the open (0.9% of GDP). The survey respondents were officially charged the reported amounts at the reception desk to obtain services they were entitled to no cost (Table 3).

The survey data indicated that health care systems successfully adapted to the new environment of deficient public financing by leveling the gaps from private money. Some territories of the RF have already passed acts legalizing such co-payments, regardless of their vulnerability as pre-empted by federal laws. For example, Health Department of the Perm District established fixed charges for each outpatient visit and each day of patient hospital stay. Kaluga District legislature considers the
incorporation of co-payment provisions of their guarantees of health care delivery. Republic of Karelia withholds 80% of the retirement of the old people hospitalized for medical/surgical conditions and redirects withheld amounts to respective hospitals. All the above is indicative of the urgent need to update the constitutional promise of universal health coverage and legally introduce patient co-payments. The present situation of unregulated collection of payments for formally free services resulted in a limited access to healthcare for low-income and rural populations. In December 1997, 20% of households with the lowest family income spent 27% of their month's budget on health services and drugs, while the richest 20% of families spent on these purposes only 9% of their budget. Local monthly averages of out-of-pocket costs of health care and drugs were at their lowest in Moscow and St. Petersburg (US$34), and at their highest in minor urban communities (US$44).

Therefore, conservation of the present gap between the constitutional entitlement of everyone to receive free health services and actual public expenditure in health sector will result in compensation of health care budget deficit with private payments and aggravate social tensions due to the lack of equity.

Efficient Health care Management
As a result of overall decentralization of government administration, health care management was also decentralized: the vertical administrative system was eliminated and segmented into distinct federal, regional, and municipal systems. In the course of differentiation the distribution of powers and competencies between federal, regional, and municipal authorities was defined hastily and imprecisely by virtue of the political situation. Some functions of the health care management were not supported by corresponding statutory instruments. The question of primary concern is the lack of regulations to compensate costs of health care provided by a territorial health care system to the population from other territories. Thus, a network of specialized interregional diagnostic and clinical centers was created, in the health care system of the Soviet period, serving the population of adjacent districts. In turn, rayons within each district could essentially differ in services available, since their health networks were widely provided health care services to the population of other rayons within a given district. Utilization of such "extra-territorial" health services was subject to thorough planning at the level of central and regional health authorities.

A single purchaser model of the health care finance, with mandatory health insurance carriers responsible for purchasing the entire scope of regular health services determined in the mandatory health insurance program for their respective enrollments, should have been implemented through the mandatory health insurance network – territorial mandatory health insurance funds and insurance companies that would contract health care providers to furnish the type and volume of services defined in the territorial mandatory health insurance program (Table 4). However, the implementation of mandatory health insurance system was incomplete, and mandatory health insurance programs stood unbalanced with actual financial flows. As a result, territorial mandatory health insurance funds and insurance companies are practically unable to finance extra-territorial services and purchase a complete range of medical services defined in the mandatory health insurance program for their populations, they serve. Thus the key concept of a single purchaser has been eroded from the mandatory health insurance system.

In turn, government health care administration agencies should have been made responsible for financing and delivery of health services rendered under federal target programs and tertiary services not included in the mandatory health insurance program, along with planning and managing utilization of these resources. However, federal and regional health authorities are badly short of resources and thus unable to act in the role of single government purchasers of health services at the territorial level and to cover costs of extra-territorial health care. Government health care budgets at different levels are usually planned with no attempt to rationalize utilization of health services financed with government allocations.

Powers and responsibilities of health care administrations and mandatory health insurance funds were not precisely delineated. This problem was intensified due to the incomplete introduction of the mandatory health insurance system: health administrations and mandatory health insurance carriers continue to fund health care facilities without any attempt to coordinate financial flows. In 1997, only 26.6% of public health expenditure was accumulated in mandatory health insurance funds (4,5). All the above created the environment where non-aligned interests of players may lead to an open confrontation between health administrations and mandatory health insurance funds, and such conflicts have already actualized in some regions.

To eliminate such problems, a reform of the existing eclectic system of health care management is required. There are two alternative approaches to such reforms.
The first approach is to recreate elements of a vertical government: administrative subordination of the mandatory health insurance fund to health administrations, centralized territorial health care budget, and ear-marked allotments to municipal health care systems accumulated at health care administrations for their subsequent disposal. This approach would allow the removal of the most acute conflicts in the health care management system, primarily those existing between health authorities and the mandatory health insurance system. Thus, federal and territorial health authorities would have the opportunity for more rational utilization of resources available to fund health care systems. The question is, would they use those opportunities to their maximum benefit? It is predictable that administrators in bureaucratic environments would have no incentives to allocate resources in such a manner as to improve cost effectiveness of care. Moreover, backward transformations may lead to the persistence of the present problems and give new rise to those organically inherent to former health care administration systems: i.e., ineffectiveness, lack of incentives to improve health care quality and efficiency, a decline in the institutional protection of patient rights, etc.

The second approach is to preserve the autonomy of the mandatory health insurance system and to implement a mandatory health insurance model, as legally conceived, to the full extent in all regions, to enforce local governments' obligation to pay mandatory health insurance premiums for non-employed population, and balance financial resources accumulated in the mandatory health insurance system with territorial benefit plans. While the polycentricity of the health care system is preserved, functions of health authorities at different levels and mandatory health insurance funds should be precisely delineated and supplied with adequate financial resources. Clear distinction of competencies between various health care purchasers should be facilitated with coordination procedures. This scenario of the reform seems more viable from the standpoint of the need to reshape health care systems in such a fashion as to make them more responsive to market economy conditions.

Insurer Role in Health Care Finance

Another peculiarity of the Russian mandatory health insurance system is that two types of entities may perform the role of insurance carriers: health insurance companies and branches of territorial mandatory health insurance funds. Health insurance companies are usually private for-profit entities. By 1997, there were 461 insurers of this type in Russia (5). Carriers of the second type are structured within government financial credit organizations — territorial mandatory health insurance funds. These funds are present in each of 89 regions that constitute the Russian Federation. In 1997, territorial mandatory health insurance funds operated the total of 1,160 branches. In 42 regions of the Russian Federation, health insurance companies are the only mandatory health insurance carriers. This role entirely rests in mandatory health insurance fund branches in 23 regions; both types of carriers co-exist in 22 regions.

In 1997, the number of health insurance companies began to decrease. By the end of that year, their number was reduced by 14% (5). The notable fact is that most health insurance companies that leave the mandatory health insurance system are forced to do so because of administrative decisions of local authorities. In some regions, such as Moscow and Khanty-Mansy district, mandatory health insurance carriers were asked for annual accreditation. This resulted in at least twofold decrease in their number, and the remaining health insurance companies proportionately increased their mandatory health insurance market shares. In other regions, such as Kursk district, private insurers were simply ruled out of the mandatory health insurance system by regional government acts. In November of 1997, the RF Government approved the Concept of Health Care and Medical Science Development in the Russian Federation (9). The Concept implied that private insurers would be responsible for health care purchasing for the mandatory health insurance system. Branches of mandatory health insurance funds might act as substitute insurers in remote low-populated areas only, where private companies could not offer their services.

With the Concept approval, however, the discussion on the appropriateness of purchasing health services for the mandatory health insurance system through private insurers did not stop. No visible competition exists between insurers. Instead, they simply deal market shares and areas of their influence and then operate in a monopolistic manner. The work of insurance companies’ in the mandatory health insurance system is widely criticized because they act as mere “middlemen” between mandatory health insurance funds and health care providers. In fact, they simply redistribute financial resources available from a territorial mandatory health insurance fund to providers for fixed interest rates to cover costs of administration, doing nothing to control utilization and quality of care and protect their customers. Opponents of the reform argue that operational costs of insurance companies and mandatory health insurance funds are too high, and that their efficacy is doubtful. In fact, average costs of administration in territorial mandatory health insurance funds and their
branches was 2.8% of total mandatory health insurance costs in 1994-97; (10,11) and health insurers' costs of administration took away 3.5% of what they received from territorial mandatory health insurance funds in 1997 (5).

To obtain any firm answer to the question of whether private insurers' participation is appropriate in the mandatory health insurance system, one should have some understanding of, firstly, of what opportunities to improve effectiveness of health care resource utilization are embedded in their position of health care purchasers for the mandatory health insurance system. Is competition of mandatory health insurance carriers a prerequisite to their effective operations? Can any positive effect be expected from private insurers' presence in the mandatory health insurance system even without any tangible competition between them?

Several studies examined the implementation problems inherent to the model of public health care finance through competing private purchasers, along with analyses of the model viability criteria and necessary conditions to produce actual positive impact upon health care effectiveness (12-14). The model of public health care finance through third-party purchasers of health care to contract providers, but without the competition of purchasers, was also analyzed. It was demonstrated that separation of purchaser and provider functions and provider contracting by purchasers would all by itself result in a system with many advantages over the model of integrated government finance and administration of health care delivery (13,15). Attention, however, was focused on provider-related aspects of such innovations and effectiveness of health care delivery. Now we are going to address institutional conditions of operational effectiveness of third-party purchasers of health services in public-financed health sector.

The level of insurers' interest in effective utilization of mandatory health insurance resources will depend on two driving forces: competitive pressures and regulatory pressures. Regulatory pressures here mean government-imposed requirements as for effectiveness and efficiency of health care purchaser function.

The level of competitive strain will depend on the following factors: (a) the number of competing purchasers for public-financed health programs; (b) enrollees' access to information about quality of competing insurers' operations and services, along with costs of access to such information and re-enrollment in another insurer's health plan; and (c) antitrust regulations, along with penalties for non-compliance and enforcement procedures.

Conditions of positive impact of purchaser competition upon effectiveness of health care resource utilization include (14): (a) government policies to encourage purchaser competition; (b) adequate level of purchasers' administrative capacity to choose the most effective ways to provide health services to the target population; (c) securities of patients' right to choose health insurance plans and health care providers; and (d) purchasers' financial responsibility for the effective use of health care resources.

While encouraging effective utilization, the competition of purchasers, however, is not the only way to achieve that goal. In local markets where the level of purchaser competition is inadequate, regulatory pressures may serve as sufficient drivers of effective health care purchasing. To be a capable factor of influence upon insurers and make them perform effectively, government regulations must meet the following criteria: 1) thoroughly specified requirements as for structure, volume, quality, and cost of health services to be provided to the covered population, along with purchaser's responsibilities to meet those requirements; 2) adequate public funding of purchasers through arrangements that encourage effective performance (e.g., stable per capita funding at rates adjusted for a variety of health risks present in the target population, with rating adjustments made not more often than once a year); 3) administrative requirements to secure effective utilization of public funds entrusted to the purchaser (e.g., mandatory submission of insurers' operation plans to check how they are going to manage patient flows and channel them into such health care facilities that are most appropriate from the standpoint of cost-effectiveness); 4) reasonable costs of the state surveillance of insurers' compliance; 5) penalties for noncompliance with state regulations and their inevitable application to all exposed violators; and 6) purchasers' qualification to make informed decisions about the most appropriate ways to render health services and ability to make health care providers respect such decisions.

In Russia, government requirements of rational resource utilization are declamatory and unspecific. The control of where government allotments actually go is weak, and cost-effectiveness control is almost nonexistent. The government steadily disregards its obligations to finance health care.

Capitation rates at which insurers are funded do not suffice to cover medical costs of benefit plans promised to the insured. Moreover, those rates are sometimes amended several times a year, which makes insurers' efforts to manage utilization and gain on economy impracticable. Regional and local government agencies often force insurers to contract health care facilities under their administration in
order to keep them running regardless of quality and effectiveness of provided care.

In such circumstances, it would be naive to expect effective utilization management from health insurers responsible for the use of public resources. Insurers prefer receiving more funds at their disposal living on their commissions (supposed to cover costs of administration), and profit from legal and illegal short-term investments of spare cash.

At the same time, some Russian insurers have demonstrated examples of institutional innovations to facilitate effective utilization of mandatory health insurance resources. Examples of effective institutional innovations include: 1) decreased costs of data communication and management; 2) automated systems for inventory management of claims and benefits and for reporting pharmacy prescriptions; 3) insurance cards for automated input of data about all health services rendered and for further claims processing and transactions with providers; 4) development of regulations to implement medicoeconomic standards, including requirements for the efficiency of mandatory health insurance resource utilization; and 5) implementation of market-driven procedures for mandatory health insurance resource allocation.

As an example of the latter initiatives, the pilot project undertaken in 1997-98 in Moscow by Max-M and Rosno health insurance companies is illustrative (16). These two companies acquired from the government the function of payer for drug benefits covered with government allocations. In the course of the pilot project, insurers detected plentiful fake prescriptions of covered drugs. The corrective actions followed, including modification of prescription blanks and better control of how they are stored and filled, resulting in complete elimination of counterfeits. Another innovation was purchasing of covered drugs through competitive biddings. The major result of the pilot project was 30% savings compared to projected costs of drug benefits in the Moscow budget (17).

Unfortunately, such examples are scarce. Unless the competition of insurers is encouraged and, which is even more important, unless government surveillance of insurers becomes really pressing with the development of more specific regulations and requirements and tools of their enforcement, the insurers will really become unnecessary "middlemen" in the public health care financing system. Development and enforcement of state regulations require much effort on behalf of government agencies. Meanwhile, governments at all levels fail to demonstrate any willingness to engage in such efforts. Conversely, many regional authorities choose to counteract the federal concept of health sector development and approve policies to eliminate private insurers from their territorial mandatory health insurance systems.

Recommendations for Government Policies

In order to resolve economic problems present in the Russian health sector, the following steps are required: 1) revision of current government guarantees of free health care, introduction of co-payments for health services provided to certain categories of population; 2) government support of voluntary health insurance development in order to absorb current shadow cash-flows from patients to providers of health services; 3) legislative requirement of financial planning operations of health care systems at regional and municipal levels – in every region, territorial health authorities, in cooperation with territorial financial authorities, municipal governments and territorial mandatory health insurance funds should annually redesign their territorial programs of health benefits, including thoroughly planned volume and structure of health services to be provided to the entire regional population and at each municipality within it; 4) implementation of systematic activities to secure transparency of expenditures from public funds by health administrations, health care organizations, mandatory health insurance funds, and health insurance companies: federal requirements on financial data to be reported, guarantees of public access to information for personal use and publication through media, and so forth; 5) elimination of shared responsibility for financing health care provided under mandatory health insurance programs – mandatory health insurance funds should become sole administrators of resources allotted to cover costs of territorial programs of health benefits; 6) enhanced requirements to health insurance companies participating in the mandatory health insurance system and their operations through more specific licensure terms and stricter monitoring of compliance; 7) creation of competitive environments in local markets of mandatory health insurance; and 8) measures to encourage health insurance companies to manage health care delivery to their enrollees.

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Correspondence to:
Sergey Shishkin
Bulatnikovsky proezd 6-1-373
Moscow, 113546 Russia
shishkin@iet.ru

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