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BALANCING THE STATE AND THE MARKET:
RUSSIA’S ADOPTION OF OBLIGATORY MEDICAL INSURANCE

Abstract:
In response to a crisis situation in public health and medical care in the late 1980s and early 1990s, Russia embarked on a program of nationwide obligatory medical insurance. Russian health reformers believed that the best, and perhaps only, way to achieve better efficiency and quality was through a rapid transition to a free health care market. The incentives created by this rush toward the market, however, have produced an array of unintended consequences. Many of the negative structural elements of the Soviet system have persisted, while the most important positive aspect of the Soviet model -- universal, equitable access to basic medical care -- has suffered. Furthermore, regulation and control have been maintained in places where the market could realize greater efficiencies. Russia is now struggling to define and implement an optimal set of policy levers which recognizes the imperfect quality of health markets, and which balances market forces with an appropriate role for government. In doing so, Russia joins the rest of the world’s nations in the search for a system of health care financing that preserves equity, access, and efficiency while controlling costs.

"To revitalize their health services, governments in the former socialist states of Central and Eastern Europe are experimenting with a new wonder drug called market mechanisms. This is rather like the doctor who gives penicillin to a patient who has a known allergy to it but will die without it. It is necessary to understand the associated dangers so that appropriate measures may be taken to prevent the treatment from killing the patient."1

"It is not my rule to shout "fire" when everything is already burnt." -- Nikolay Gerasimenko, Chair, State Duma Committee on Health Protection2

Russia’s challenge in reforming the system of health care it inherited from the Soviet Union has been to preserve the positive elements of the old regime while eliminating inappropriate incentives and structural deficiencies.3 This paper will review relevant details of the Soviet system of health care, trace the recent history of reform of that system, outline theoretically the ways in which health care markets are imperfect, and most importantly, analyze the dimensions along which the Russian program of obligatory medical insurance has failed to compensate for those imperfections with an appropriate balance of market forces and government intervention.

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The Soviet System of Health Care

Chief among the accomplishments of Soviet health care was entitlement of the entire population to a comprehensive range of medical services, despite the wide geographic spread of the country and the sparseness of much of its rural population. This universal access was maintained
through state ownership and management of an extensive, structurally integrated network of hospitals, clinics, and other facilities. By law, government financing guaranteed equity, promising medical care free at the point of service to every Soviet citizen.

For decades, state control of medical care provided the Soviet Union with much to boast about. There was continual improvement in a wide array of health indicators, including life expectancy, mortality rates, and control of infectious disease. All of these gains were achieved, however, through a strategy of extensive growth typical of the Soviet system. Health care was not able to escape the structural disproportions and perverse incentives which plagued the rest of the Soviet economy as a result of gross output-oriented central planning.

Specifically, Soviet health care facilities were required to meet quantitative plan targets. Hospitals were funded according to their success in fulfilling a centrally-set plan for numbers of beds occupied, and polyclinics were budgeted according to "capacity," meaning the number of patient visits its facility and staff were capable of handling. Because each citizen was assigned to a polyclinic through his residence or workplace, and polyclinics generally were not able to choose secondary care providers, there was no consumer choice of physician and no competition between treatment facilities. Physicians were paid according to a strictly defined salary scale which varied only with their years in service and level of specialty and training. Incentives for quality and efficiency of care were therefore absent, and polyclinic physicians became "indifferent dispatchers," issuing the sickness certificates which excused patients from the workplace and referring them to hospitals for most treatment.

Hospitals, on the other hand, operated under incentives to overtreat, in order to keep the maximum number of patients constantly occupying the greatest possible number of beds. This incentive structure was reinforced by housing shortages and cramped living environments throughout the country, making treatment at home problematic; by high rates of employment, so that relatives were not available at home to tend to ill or recovering family members; and by the system of sickness certificates through which trade unions paid workers as much or more in daily wages if they were hospitalized than if they were on the job. As a result, in the early 1980s, the Soviet Union recorded 2.8 hospital days per person per year, compared with 1.2 in the United States. In order to meet and exceed plan targets for numbers of occupied bed-days, local health authorities not only overcrowded wards and placed beds in hospital hallways, but routinely opened "hospital" beds in converted boarding houses and hostels. The latter were substantially cheaper to operate than standard facilities, but were of dramatically low quality, frequently lacking indoor lavatories and/or running water.

Treatment regimes were standardized according to central plans, so that a specific length of hospital stay was indicated for each category and type of disease or hospital procedure. In general, these norms were approximately double the average length of treatment in the United States, and
hospitals nearly always kept patients for the maximum allowed number of days. Most facilities also had to meet plan targets for numbers of specific procedures performed, resulting in unnecessary tests and surgeries.

These incentives created an overreliance on secondary and tertiary care and excessive specialization at the expense of primary care and public health services, a lopsidedness reflected over time in investments in both physical plant and human capital. Medical education stressed the development of narrow skills, to the almost total detriment of training of generalists or family practice physicians.

These systemic pressures to provide more, and more expensive, services constantly battled against insufficient funding. Soviet health care was financed according to the "residual principle," where health (along with other non-priorities such as education and light industry) received whatever was left over after key sectors like defense and space had received their full budget allocations. As a result, Soviet medical care consistently consumed about 3% of GNP, compared with figures three to four times higher in Western industrial societies. Hospitals and clinics were severely underequipped, in terms not only of sophisticated medical technology, but also such basics as disposable syringes. Physicians' state-specified salaries were low, only about 75-80% of the average Soviet skilled worker's wages.

In the absence of structural incentives, patients had to come up with other reasons for physicians or other caregivers to provide them with reasonable attention and high-quality service. Patients routinely made sometimes substantial side payments in order to move rapidly to the front of a queue, to see providers outside their assigned catchment areas, or sometimes to receive any attention at all from nurses and orderlies during a hospital stay. The pervasive obligation to offer these gratuities rendered the claim of equitable access to free medical care largely invalid. In 1991, it was estimated that illegal payments amounted to as much as 25% of total expenses for health care.

The Search for a New Model: Early Attempts

Soviet medical care eventually reached the limits of what could be accomplished through extensive growth. The absence of incentives for intensive development, for gains in efficiency and productivity, caused many of the Soviet achievements in health outcomes to begin to stagnate or even decline by the 1980s despite its huge network of medical facilities and high per capita number of physicians. Reformers in a handful of Soviet regions began to search for a new structural model. This search culminated with the New Economic Mechanism (NEM), an experimental approach to health care financing implemented from 1988-1991 in the city of Leningrad (St. Petersburg) and the Kemerovo and Kuybyshhev (now Samara) oblasts. In an effort to encourage more efficient and higher quality medical care, the NEM fundamentally changed the way health care was funded in
these three regions. Most money was now channeled from the state budget directly to polyclinics on a weighted capitation basis (payments per registered client, regardless of the frequency or intensity of each client's usage of the facility, regionally adjusted for the age and gender structure of the population, morbidity and mortality rates, working and living conditions of the population served, and/or the quality of the region's medical facilities). The clinics would therefore have incentives to offer more user-friendly and high-quality services, since patients could choose their clinic and general practice physician, and the money would follow the patients' choices.

The polyclinics would then act as fundholders, referring patients to hospitals when necessary and paying for their hospital-based treatment. Clinics began to experience an incentive to treat patients on an outpatient basis whenever possible. Hospital fees were set on the basis of diagnostic and procedure groupings, where each procedure performed was reimbursed according to a standard average rate. Hospitals lost their earlier incentive to overtreat and to keep patients for unreasonably lengthy stays. If particular instances of hospital care were found to fall below specific standards of quality, polyclinics could refuse to pay or insist on reduced levels of payment. Clinics, behaving as "general contractors," also had the right to select which hospitals they would choose as "subcontractors," providing yet another lever encouraging higher-quality hospital performance.15

Of course, the NEM could not correct every structural deficiency.16 Polyclinics continued to have difficulty accurately calculating their client lists, since initial assignments could be based either on the patient's residence or workplace. Physicians in most cases continued to receive fixed salaries, so they did not feel the full force of the new incentive structure. Health authorities had to monitor quality standards carefully to counter the polyclinics' temptation to deny referrals to hospitals in cases where inpatient care was appropriate. Nevertheless, all three regions where the NEM was implemented reported dramatic improvements in efficiency and quality of care.17 In Kemerovo, the total number of hospital beds declined by 10% from 1987 to 1989; waiting lists for laboratory tests and specialist consultations disappeared; and patient complaints were cut in half.18 In Samara, the average length of hospital stay was reduced by 7%, and the total number of hospital beds in the oblast was reduced by 5,500.19

In 1991, just as the NEM's success was encouraging its implementation in about a dozen other Russian regions, Russia's economic system collapsed to the point that budget financing became unpredictable and inadequate. The shortage of budget funds, under highly inflationary conditions, made it impossible for the NEM to continue. Hospitals quite reasonably demanded rapidly escalating levels of payment for treatment of patients referred to them, but the polyclinic fundholders, operating with budgets based on government-allocated fixed capitation payments, could not keep up. In essence, the hospitals bankrupted the polyclinics, and the experiment with the New Economic Mechanism came to an end.
The Search for a New Model: Obligatory Medical Insurance

Faced with dire funding shortages and continued structural deficiencies in the health care system, Russian legislators, prodded by a small, ad hoc group of academics who had been studying health reform in Kemerovo and other regions for several years, decided to plunge into a rapid transition to a market-based system of nationwide obligatory medical insurance. It is somewhat ironic that, at the very moment the United States and other Western countries were debating appropriate and necessary ways in which to introduce more government intervention into their health sectors -- intervention required because of known market failures in the health sector -- Russia was planning and implementing an overnight massive de-statization of medical care. Russian health reformers were intent on discarding virtually all elements of their Soviet past; for example, using Britain's system as a model was summarily rejected because its socialized, single-payer principles were too familiar.

Russian legislators in 1991 were intent on extending "shock therapy" into the health care system, convinced by both the plummeting health status of the population and the catastrophe in health care financing that something had to be done immediately. According to a report detailing a late 1990 meeting of the RFSFR Supreme Soviet Committee on Health Protection, the deputies concluded that "the introduction of new principles of financing of the branch cannot be postponed. This is true despite the fact that a system of market economics, one element of which is medical insurance, has still not been worked out in the country." The medical profession was similarly insistent on the need for immediate action. Threatened by wages unable to keep pace with inflation, physicians in at least one region formed an ad hoc committee to defend their interests. One of their primary demands was the introduction of compulsory medical insurance, without delay.

According to several of the architects of the reform effort, it was not difficult to get legislators on board. Major reforms were in vogue at the time, particularly among the many new faces just entering the political arena for the first time. In addition, the infant Russian insurance industry, which had already sprung up to serve other sectors, began to lobby extensively for what it perceived to be potentially lucrative opportunities should market-based health insurance become the law of the land. After having studied carefully a wide variety of Western models of health care financing, study which included several trips abroad by both academics and legislators, the reformers came to the conclusion that "market forces could do it all."

The determinants of variance in health status between populations and nations are not precisely understood. It is well known, however, that the health care system itself constitutes only a small part of the equation. One study estimates that preventative and curative health care services determine only about 10 percent of health outcomes, compared with 30 percent from wealth and associated socioeconomic factors, 50 percent from known behavioral and lifestyle risk factors, and 10 percent from environmental pollution and occupational risks. It is therefore reasonable to ask why Russia
chose to focus all of its energy and resources into correcting only one-tenth of the problem. Indeed, some initial proposals for the insurance system called for as much as 20 percent of insurance revenues to be devoted to public health measures, broadly defined: improvements in workplace safety, public and occupational hygiene measures, etc. The answer lies largely in overall perceptions of the health crisis in the early 1990s and in the art of the possible. The sizeable number of people with acute medical problems had to be dealt with immediately, and the health care system had to be reformed before it could accomplish that task. This effort was quite challenging and consumed all of the limited financial resources available for health care, so that it was not feasible to turn to the longer-term, more deeply embedded causes of poor health status.

Russian reformers therefore crafted the system of obligatory medical insurance which was eventually signed into law in April of 1993. Their challenge was to increase efficiency and equality of health care through market forces, while still preserving the virtues of equity and access which characterized the Soviet system. World experience with health care financing gave the reformers a wide variety of models from which to choose: private financing, via out-of-pocket payments or voluntary insurance, vs. public financing through general revenues or a system of universal compulsory insurance; and organization of clinical services through public, private not-for-profit, and/or private for-profit ownership. In theory, the type of financing does not necessarily dictate the form of ownership, or vice versa, and market-based incentives can be constructed as long as the source of funds is institutionally separate from the means of service delivery. Russian reformers wanted to preserve universal access and equity by continuing with essentially public financing, but introduce market forces through the vehicle of an insurance mechanism. The requirement for the population to make substantial out-of-pocket payments was rejected outright, both conceptually, since direct charges cannot protect most citizens against the risk of catastrophic illness or finance increasingly expensive routine health interventions, and practically, since inflation was wiping out Russians’ savings and far outpacing most incomes. These factors led to the choice of a universal, mandatory medical insurance system. They also decided that, in order to foster competitive pressures for quality improvements, both public and private forms of ownership of health care facilities should be permitted.

The major thrust of the new Russian obligatory medical insurance system was its mechanism of revenue generation. Because government health budgets had been inadequate, unreliable, and declining for several years, Russian reformers concluded that a more predictable, and most importantly, targeted source of health care financing should be the primary goal of the reform effort. The insurance scheme calls for a 3.6% payroll tax on employers, with 3.4% going to oblast-level governmental health insurance Funds, and 0.2% going to a federal-level Fund to provide subsidies to ensure equalization of circumstances across regions and to pay for a variety of types of medical care deemed to be of national significance: oncology, tuberculosis, several sexually-transmitted diseases,
and treatment required as a result of major accidents or natural disasters. In addition to these contributions to benefit working people, municipal governments are to make payments to the Funds on behalf of children, pensioners, housewives, and the unemployed, at a rate agreed to at the oblast level but not below the average regional contribution employers make for each worker. In this way, health care financing according to the "residual principle" becomes a thing of the past, since the health sector no longer has to compete with other federal funding priorities. The medical insurance Funds are isolated from the unpredictable vagaries of formation and implementation of the government budget.

The reformers debated several different structures of the payroll tax. One proposal suggested differentiating rates paid by enterprises according to working conditions, ecological effects of production, and the age and gender structure of the work force. These rates would be reevaluated periodically in an effort to encourage improvements in businesses' working conditions and environmental impact; a factory which installed antipollution devices, for example, would be rewarded with lower health insurance premiums for its workers. This approach was rejected in favor of the uniform payroll tax, however, in the interest of social solidarity, and to eliminate the potential for employers and insurers to discriminate against individuals or populations based on perceived health risks.

The regional Funds aggregate all insurance payments from enterprises and municipal governments, and distribute them among a network of private insurance companies on a capitated basis. Insurance companies then contract with polyclinics and hospitals for provision of medical care to their clients, with payment schemes constructed on the basis of capitation, fee-for-service, or diagnosis-related groups, as determined through negotiation. It is primarily the responsibility of the insurance companies to carry out formal procedures for quality maintenance and control in the clinical facilities. The architects of the insurance program intended for the major structural element of the reform to be the separation of purchasers from providers of health care. By creating the insurance Funds and opening the door to insurance companies, the incentive structure determining the behavior of providers should radically change. Independent payers and insurers, according to the reform, should interact with hospitals and polyclinics only through contractual mechanisms, and since the third-party payers enjoy flexibility in deciding with whom to conclude those contracts, they can reject the services of inefficient or low-quality medical facilities. The traditional dominance of a perverse incentive system, which encouraged providers to be responsive to inflexible, illogical plan targets, would give way to the needs of the patients on whose behalf the insurance companies and Funds would act. The balance of power between the payers and providers would change completely. The diktat of administrative forces would be replaced with a consumer-focused market, the forces of which would dominate the system on two fronts: insurance companies compete for enrollees, who will presumably make their selection based on the treatment institutions with whom the companies
have contracted, and also on the companies’ success in carrying out their quality control function: and hospitals and polyclinics compete for business from insurance companies. The excess capacity which characterized the Soviet system will in theory disappear, as unused beds and inadequate facilities will be permitted to go out of business: the market will correct all structural deficiencies.

Health Markets Are Not Perfect Markets

The Russian reformers failed to consider the degree to which health markets are imperfect, and therefore not necessarily appropriate for the same degree of "shock therapy" as the rest of the economy. Many of the participants in the reform efforts now observe that, although everyone at the time agreed that the system had to undergo dramatic change, few people had carefully considered the structural implications of the new model they were adopting. Scholars have long recognized the nature of the market failure peculiar to health: expenditures on health care may be quite substantial, yet some people still do not receive all the care they need, and others receive care of questionable value.

First of all, in economic terms, health services are not homogenous private goods; they do not exhibit the properties of excludability (an individual must pay for a good in order to receive it); rivalness (one individual’s use of a good precludes that good’s use by another); and rejectability (an individual can choose not to consume a good). With few exceptions, for example, people who are injured or ill do not have a choice about whether or not to seek medical care. They cannot choose to forego treatment because they are not satisfied with the market price or quality of that treatment. Similarly, health education or immunization to control infectious disease are products which benefit people who do not directly receive or pay for them. This situation is likely to produce free riders, individuals who will continue to enjoy the benefits of the services without paying. The market will not provide a socially desirable amount of services to those who need them if those services are not perfect private goods or have externalities (spillovers of benefit or harm from one individual to another). Some kind of intervention in the market is required.

Second, health consumers do not enjoy perfect information. Generally, the only decision a patient makes independently in the health care process is the moment of initial contact due to illness or injury; from that point forward, it is the provider who possesses the necessary expertise and information base to determine the choices made during the course of treatment. This asymmetry results in a situation where, if the provider's income is linked to the amount of treatment, and particularly if a third party pays or reimburses part or all of the expenses, unnecessary care may be rendered even if that care is not in the patient’s best interest. The patient is even further disadvantaged if he is extremely ill or in need of urgent care, rendering him unable or without time to seek alternative information or second opinions.
Other health market imperfections include: 
* a relatively small number of individuals uses a large percentage of a population's health resources; 
* the costs of extensive medical care, if paid out-of-pocket, are likely to deter less wealthy individuals from seeking treatment; in other words, legitimate demand for services may be deterred by high prices; 
* the presence of third-party payers is likely to render individuals immune to some degree to the costs of medical care, making them less likely to take measures to maintain their health; 
* supply creates its own demand, in that the development of new medical procedures and technologies automatically results in consumers of those goods and services; 
* it is in the interest of insurance companies to practice "adverse selection," providing insurance only to individuals who pose a minimal risk of health problems; 
* significant economies of scale and barriers to market entry apply to the production of many health services, leading to oligopolistic or monopolistic hospitals and specialists in many areas; and 
* the presence of third-party payers means that, if there are cost savings realized from market-based efficiencies, those savings are likely to benefit those private payers rather than society at large.

Because of these imperfections, health markets cannot be left to the invisible hand. It has long been recognized that government intervention and regulation must play at least a minimal role in the health care sector in order to ensure at least some degree of socially desirable equity, access, and efficiency. Indeed, it may be more accurate in the Russian context to say that market instruments, carefully contrived, must play at least a minimal role in the health care sector in order to achieve state policy objectives. A strong government role is necessary to ensure some of the most fundamental elements of a fair and comprehensive system of health care, and yet government action is insufficient or even detrimental to the achievement of other important goals (as the Soviet experience demonstrates). As governments craft the relative positions and roles of state intervention and market forces in medical care, they must be very careful about the incentive structures they create, lest they unleash unintended consequences and exacerbate the very problems they are trying to solve.

In general, governments have to take steps to correct for the following concrete results of health market failure: a degradation of universal access to necessary health care regardless of income and medical risk; the existence of providers who offer low-quality or unsafe care; and escalation of health care costs due to the tendency of providers and/or consumers to exploit the largess of third-party payers through the provision of excess treatment. They can do so through a basket of policies which requires insurers and providers to provide equitable access to care; correct for patient/provider information asymmetry by controlling the general quality of medical services, monitoring adherence to professional standards among providers and insurers, and maintaining regulatory regimes for the manufacture, testing, and sale of pharmaceuticals; preserve the confidentiality of medical records; and control expenditures through out-of-pocket payments, spending caps, or countervailing incentives at the system, hospital, or individual provider level. The last point in this list is crucial. If cost
controls are accomplished de facto rather than through deliberate policy, then serious holes will be left in the health care safety net as the poor and infirm are most likely to be neglected.

Obligatory Medical Insurance in Russia: Trials and Errors

Russia made the mistake of trying to implement market-oriented changes in the health care system too quickly, without a careful analysis of these elements of health market failure. Excessively rapid destatization, decentralization, and change in mode of financing was introduced before the institutional capacity to implement the changes had been established. As might have been expected, these policies have led to near collapse of the health care sector during this transition. The switch to obligatory medical insurance in Russia did indeed provide additional revenue for health care, although not as much as expected. But more importantly, it has failed to find the proper balance and placement of state regulation versus market forces. Regulation and control have been maintained in places where the market could realize greater efficiencies; on the other hand, along other dimensions, the market has been permitted to destroy some of the positive elements of the Soviet system which could have been retained (and could be regained) through government intervention.

The first key error made by the Russian reformers was a focus almost exclusively on bringing new, substantial, and protected sources of money into the health care system, to the exclusion of consideration of the administrative environment through which those funds would be spent. Simply changing the method of revenue generation, contrary to some expectations, did not change managerial and incentive structures. It is true, however, that charging the obligatory medical insurance Funds with responsibility for collection of the health-related payroll and municipal taxes has resulted in high rates of tax compliance -- much higher than the government experiences for general revenues. The Kemerovo Oblast Obligatory Medical Insurance Fund, for example, currently collects 75-78% of the money due to it; the Moscow City Fund enjoys an even higher success rate of 90-95%. Both of these regions assign more than half of their employees to the full-time business of tax collection.

Unfortunately, this success in tax collection has not translated into a permanent windfall for the health sector. Polyclinics and hospitals report that in the first two or three years of the insurance system, from 1992 through 1994, the budgetary situation did indeed improve dramatically, as insurance-related payments from the regional Funds augmented allocations from the state budget. In 1994-1995, however, local governments began to reason that if medical facilities were receiving funds from the insurance system, then state health allocations could be cut by a commensurate amount, and those scarce budget resources could be diverted to other priorities. In other words, in the long run, the obligatory medical insurance system has not necessarily resulted in more money for health care. Some Russian health insurance officials argue, however, that had the health sector remained completely budget-financed, the national economic crisis would have left health care much
worse off than it has been under the insurance model; education and cultural expenditures, for example, fell by 27 and 31 percent, respectively, from 1992-1995, making the 10 percent decline in health expenditures look mild by comparison.44 The "replacement" income provided by the insurance taxes protected hospitals and polyclinics from an even more severe crisis.45

Most analyses of the Russian obligatory health insurance system continue to focus on its dire financial straits. These arguments imply that many, if not all, of the health sector's problems could be solved with sufficient infusions of money, ignoring the uncorrected structural defects in the design and implementation of the insurance legislation: the continued lack of competition between payers and providers; the consequences of unchecked devolution of financial and managerial authority; the neglect within the current incentive structure of cost and utilization control; the marginalization of insurance-based incentives under a mixed budget-insurance model; the degree to which ambiguities and lack of specificity of the insurance law leaves the health sector vulnerable to political machinations; and the lack of explicit attention to continued structural imbalances within and between hospitals and polyclinics.

Lack of competition

Despite the implied provision in the insurance legislation that increased efficiencies in health care would be effected through competitive pressures between payers and providers, these efficiencies have not in most cases been realized. The Russian government has not taken the necessary steps to create an environment within which competition is encouraged or even possible, and it has not recognized that market competition cannot create all of the incentives desired in every health care environment.

It might be expected that one legacy of the Soviet health care system, with its oversupply of physicians and hospitals beds, would be a fertile environment for competition. The Soviet system, however, was constructed on a highly regionalized, vertically integrated basis. Patients were assigned to the single existing polyclinic in their workplace or neighborhood. If they required inpatient care, they were referred to the single existing hospital in their region, and if more specialized care were indicated, they were sent to the appropriate secondary or tertiary facility closest to their home. In the name of efficiency and control, duplication of facilities was meticulously avoided, resulting in a situation where most hospitals and even polyclinics enjoyed a virtual monopoly on health care in their geographic areas. This monopoly has persisted to the present day, making it difficult for competitive incentives to prevail in the current network.46 Substantial economic and regulatory barriers, such as high start-up costs and the lack of effective capital markets, inhibit the entry of new providers into many of Russia's health care "markets."47 Assuming that these problems can be overcome, it will still be difficult to achieve competition in Russia's large number of sparsely populated rural regions, where the small number of inhabitants may not support more than one
polyclinic. In addition, economies of scale may make it inappropriate to dismantle some hospital monopoly situations.

Russian health authorities continue to resist competitive contracting, since their authority is diminished to the degree that budget financing gives way to market incentives.48 Many hospital and polyclinic managers are also reluctant, despite the promise of additional resources, to depart from the familiar administrative system in favor of the demands and uncertainty of a competitive environment.49 Even the Russian people remain dominated by a culture not completely comfortable with choice between competing health care providers. Old habits of passive dependence on the paternalistic state health care system have not been supplanted by individual initiative in seeking high-quality care.50 Even the head of the Moscow City Obligatory Medical Insurance Fund, one of the most effective champions of health system reform, reveals his lack of faith in competitive forces by commenting that "basically all the polyclinics in Moscow are the same -- the same level of services, the same qualifications of physicians."51

The one way in which Russian patients have been exercising choice is by switching physicians within their assigned polyclinics. It is unclear, however, given the largely fixed wage structures under which most physicians operate, that this dynamic provides them with an incentive to provide better care.52 In fact, the incentive may operate in the opposite direction: within a single polyclinic, if one physician attracts all the patients, and the other attracts none, they will still receive the same salary. The only reward to the more popular, presumably competent and compassionate, physician is an increased workload.53 In theory, chief physicians in each clinic, who determine salary payments to individual doctors under their management, could create more effective incentive structures, but they are unwilling to promise incentive bonuses when their facilities' total incomes are so unstable and costs for operating expenses and pharmaceuticals are so unpredictable.54

In urban areas where competition is feasible, the legislative environment remains hostile to privately-owned new entrants to the health care market. Currently, for example, Moscow's four privately-owned polyclinics are not permitted to participate in the obligatory medical insurance system.55 Private physicians, by law, are also not allowed to issue the sickness certificates that permit a patient to take time off from work, to prescribe narcotic drugs, or to give the discount on pharmaceuticals to patients with special benefits (war veterans, etc.).56

A competitive environment has similarly failed, in some parts of the country, to dominate the operational environment of the insurance companies assigned with the task of purchasing health care under Russia's obligatory medical insurance legislation. It is important for some sort of competitive or regulatory mechanism to police not only providers, but payers, to make sure that they are buying for their clients appropriate packages of acceptable-quality medical care.

In all of Russia, more than 600 insurance companies are working in the obligatory medical insurance system, but 330 of those are in just three cities: Moscow, St. Petersburg, and
Yekaterinburg. In the remaining regions, the number of licensed insurers varies from zero to four.\textsuperscript{57} Insurance companies simply do not perceive the potential for profit in heavily rural areas, or regions in which health risks are high due to excessive environmental degradation. In about a third of Russia's regions, where no insurance companies have entered the market, the oblast-level Funds operate as monopsony purchasers of health care services.\textsuperscript{58} Where there is more than one insurer, in many cases the Funds negotiate with insurance companies for rigid assignments of catchment areas, leaving employers or individuals with no choice in the matter.\textsuperscript{59} Insurance companies therefore often do not have to compete for subscribers, giving them few incentives to conduct business with the patients' best interests as their top priority. A competitive situation would encourage insurance companies to offer packages of benefits beyond the minimum mandated by law (difficult to do anyway, given limited funds), and more importantly, to institute meticulous and comprehensive monitoring and control of quality in clinics and hospitals; this is currently taking place only in a handful of urban areas.

In order for competition truly to foster incentives for greater efficiency and quality of medical care, more government intervention will be required. Necessary steps include collection and dissemination of information about the performance of health care providers; effective application of negative as well as positive incentives, including permission for inadequate polyclinics and hospitals to go out of business; legislative changes providing a level playing field for public and private clinical facilities; and recognition that market competition may not be appropriate for every health care environment, so that management of the market with provision of regulatory incentives for better performance might be warranted.\textsuperscript{60}

\textbf{Devolution of managerial and financial authority}

Operating on the assumption that decentralization of planning and management of health services can improve both efficiency and responsiveness to local needs, Russia concentrated almost complete budgetary and administrative authority in its obligatory medical insurance system at the regional level. In some cases, however, decentralization can be counterproductive, aggravating existing inefficiencies and inequities in the health care system.\textsuperscript{61} Each region, for example, now wants to create its own unique network of health care facilities, creating unnecessary duplication and fostering unwise capital investments -- construction of facilities and purchases of expensive, specialized equipment -- which divert scarce resources from more pressing needs. The Tula region, only a short distance from Moscow, for example, has created a medical school which currently enrolls only thirty students.\textsuperscript{62} This "atomization" of the health care system, accompanied by a process of territorial "sovereignization," leads to the inefficient provision of highly specialized care without even the possible side benefit of competitive efficiencies.\textsuperscript{63} Even worse, in those areas where particular specialized facilities have not been constructed, patients requiring those types of
medical care now as a rule must pay handsomely for treatment in facilities outside their home
regions. Sometimes an individual’s employer or insurance company will cover treatment provided in
a different oblast, but often payment must be made out-of-pocket.

The Soviet-era guarantee of equal and universal access to medical care has therefore suffered
as a consequence of decentralization.64 Russia’s regions have experienced vastly differing degrees
of success in coping with the economic turmoil of the last several years. Some currently enjoy a
substantial industrial base from which to draw both general and health-specific tax revenue; others
still suffer high levels of unemployment and significant local government budget deficits. The
Federal Obligatory Medical Insurance Fund, which receives 0.2% of national health insurance
payroll taxes, is supposed to provide equalization subsidies, but the differences between the richest
and poorest regions are beyond the Federal Fund’s ability to compensate. Per capita health
expenditures in Moscow, for example, were 720,000 rubles in 1995, while in the oblasts of the
Northern Caucasus the analogous figure averaged 130,000 rubles.65 This disparity translates
directly into differential access to health resources and quality of care. For instance, in Moscow the
formulary of covered pharmaceuticals under the obligatory medical insurance system comprises over
500 different drugs; in many other regions, only 150 drugs are covered.66

The devolution of financing to the local level has hit federal-level health care clinical and
research facilities particularly hard. Obligatory insurance is not permitted to pay for treatment in
federal-level hospitals, and state budget cuts have affected health care particularly severely at the
federal level.67 In order to stay afloat, many of these clinical facilities have begun to demand out-
of-pocket payments for supposedly free services, and federal-level research institutes without
recourse to this source of income have simply closed down. As of early 1997, over half of federal
medical institutions were closed.68 Valuable scientific research has come to a halt, and access to
unique providers of highly specialized medical treatment has either been shut down or become
unaffordably expensive for most Russian citizens.69

Neglect of cost and utilization controls

When governments around the world think about reform of health care systems, they generally
have three fundamental policy objectives in mind: access, efficiency, and cost control. Russian health
reformers in the early 1990s recognized the importance of retaining the first and improving the
second of these features in their own health sector. Because of the historical underfunding of public
health and medicine in the Soviet Union, however, they concluded that cost control could be
ignored. In the words of one of the reform’s main architects, writing in 1991 and 1992: "Pursuing
explicitly the objective of containing costs...is not a decisive factor for Russian health care reform,
since the system is devoid of most needed items, and what is required is the inflow of financial
resources"; "contrary to Western health systems we are planning to make the Russian health care
In essence, Russia replaced the goal of cost containment with that of enhanced revenue generation.71

Russian reformers failed to realize that, if the incentive structure dominating the behavior of providers were not changed, a serious mismatch might arise between the level of medical care promised and delivered to the population and the amount of funding available to pay for that care. Indeed, it might be argued that, under conditions of severe underfinancing, cost and utilization controls acquire even more importance in order to ensure that this mismatch does not develop. "Giving up cost controls under the assumption that health insurance will regulate itself is courting disaster."72

According to Russia’s insurance legislation, insurance companies can make payments to health care providers through any one or a combination of a variety of mechanisms: capitation, fee-for-service, diagnosis-related-groups, or any other methods on which they mutually agree. Each region is free to choose its own framework within which these negotiations and payments may take place. The problem lies in the fact that many of Russia’s regions have continued, within the framework of the obligatory medical insurance system, to maintain essentially the Soviet structure of incentives for hospitals and polyclinics; the more procedures they perform, the more money they are supposed to receive. In these instances, the insurance mechanism is not functioning at all; instead, the Funds and insurance companies are simply acting as indifferent channelers of money rather than as conveyers of desired incentives. This leads Russia to the same type of problems experienced by the United States before the advent of managed care. If providers are paid retrospectively according to a fee-for-service or other model that rewards on the basis of quantity, and if third-party insurers are the ones actually making the payments so that individual patients do not bear the costs of treatment, then incentives for overuse of the health care system and excessive, unnecessary treatment go unchecked. In economic terms, the customers and suppliers are both encouraged to create more demand. This dynamic causes health care costs to skyrocket.

When Russian reformers first conceived the obligatory medical insurance system, they did not attempt to match the demand for medical care embodied in the list of mandatory covered benefits with the supply of revenue likely to be generated by the 3.6% payroll tax and municipal contributions for non-working citizens. The Russian people continued to operate on the basis of their constitutionally-guaranteed right to comprehensive medical care without having to pay at the point of service. But under inflationary conditions, and the limitations of revenue generation imposed by the health insurance legislation, the Russian government’s obligations to its people could not be matched by available resources -- and the incentive system controlling the care provided by clinical facilities has done little or nothing to encourage more careful or efficient use of scarce resources.73 The costs of providing medical care according to the base obligatory medical insurance program to
residents of the Leningrad Oblast in 1994, for example, was 86 billion rubles (in 1994 prices); that
year, the entire budget of the oblast was only 95 billion rubles. On the level of the individual
facility, in Voskresensk’s City Hospital Number One, located in the Moscow Oblast, services worth
1.33 billion rubles were rendered to patients in the first quarter of 1995. Insurance payments to the
hospital to cover these patients, however, amounted to only 530 million rubles, or around 40 percent
of the total bill. Clinical facilities across Russia find themselves in an identical situation, as the
amount of insurance payments and payment structures fail to correspond with the population’s needs
for basic medical care. Essentially, hospitals and polyclinics are obligated to provide care in
accordance with the basic obligatory medical insurance program, but nobody is obligated anywhere
in the system to pay for this care.

In Kemerovo and a handful of other oblasts, health reformers are working with government
officials to craft ways in which regulatory intervention might address this problem. Kemerovo is
currently implementing a solution in which municipal governments, health insurers, the insurance
Fund, and providers plan prospectively for the volume of health care to be provided in the region
over a specified period of time, paying in advance for a specific volume of care and therefore
explicitly limiting the amount of treatment to the level of available financing. This planning
mechanism, of course, directly implies that rationing of health care must take place, since only a
limited amount of medical care will be available to a given population over a given time period. But
de facto rationing is taking place anyway, as hospitals and polyclinics require questionably legal out-
of-pocket payments in order to compensate for the lack of funding forthcoming from the insurance
mechanism. Kemerovo’s health authorities reason that, under their new system of cost and
volume contracts and global budgets, the rationing mechanism will ensure that urgent and expensive
care is provided to people with the most legitimate medical need, not those with the most money.
The only alternative to these measures is to begin to require substantial cost-sharing by patients,
which would sacrifice the important principles of equity and access.

Mixed incentives from budget-insurance financing

Russia’s obligatory medical insurance legislation remains vague in its specification of the
relative roles and responsibilities of local health authorities and the medical insurance Funds. As a
result, in most regions the state health administration bureaucracy has retained a substantial role not
only in provision but in funding of health care. Almost twelve percent of the Russian population
lives in regions where health care funding is still channeled primarily through the state budget, and
not only insurance companies but the insurance Funds play a marginal role. Even in oblasts
where the insurance companies and Funds operate as legally mandated, a “dual economy” still exists,
where the insurance system -- attempting, at least, to provide market-based incentives for quality and
efficiency -- operates side by side with budget payments to clinical facilities based on archaic
performance indicators. Only about 30 percent of Russian health expenditures are currently based on contractual relations between payers and providers.

The web of arrangements by which insurance and budget payments co-exist becomes bewildering: in some areas, the budget pays for all ambulatory care while insurance pays for all inpatient care; in others, insurance covers only inpatient care for adults; in many, workers fall under the insurance system while the budget makes payments directly for the non-working population. The Federal Obligatory Medical Insurance Fund has even recommended that clinical facilities' housekeeping expenditures, including utility bills, be paid out by local budgets, in order to insulate the insurance system from frequent and unpredictable price increases for these services.

This mixed budget-insurance model creates conflicting incentives for health care providers. If Russia is going to move forward with obligatory medical insurance, it cannot do so in isolation from the rest of the health care system. Hospitals and polyclinics need clear, consistent incentives transmitted through stable and predictable funding channels. Currently, insurance provides an insufficient percentage of clinical facilities' income for the incentives it creates to dominate the structure of health care delivery.

The primacy of politics

The continued dominance of budget financing, together with the perceived structural failures of the obligatory medical insurance system, have left the door open to a significant role for political maneuvering and posturing about Russian health care financing.

On the level of the individual clinical facility, budget financing has forced chief physicians and other hospital and clinic administrators to spend a substantial amount of their time lobbying municipal governments for increased shares of scarce government resources. In addition, treatment facilities whose physicians or other personnel can boast personal connections to high political officials also more often than not enjoy priority when it comes to funding for purchases of expensive, sophisticated equipment or needed construction or repair projects.

On the national level, institutional opposition to the insurance program has understandably existed since its inception, particularly from the Ministries of Health and Finance and local governmental health authorities who found their budgetary and administrative positions curbed by the new insurance companies and Funds. The Finance Ministry resents the existence of a separate, untouchable pool of revenue that it cannot use for its own needs. Some analysts have speculated that many of the problems with underfunding of the medical insurance system, particularly the refusal of many local governments to make the required payments on behalf of citizens who do not work, are deliberately politically motivated. In fact, in twelve regions, local governments have illegally raided the health insurance Funds, using the money for such non-health-related projects as housing construction. If lack of revenue results in ineffective operation of the insurance mechanism, then
local health authorities can argue in favor of scuttling the whole regime and returning to them their excised piece of bureaucratic turf.\textsuperscript{86} Governmental health officials have also tried to argue that the insurance system incurs unnecessary and unacceptable administrative costs, and that the insurance "middleman" (also referred to as a "parasite") wastefully eats up resources that would be better spent directly on patient care.\textsuperscript{87} According to reputable accounts, however, administration and maintenance of the regional insurance Funds only consumes between 2.6 and 2.8 percent of total insurance expenditures, an amount that is more than compensated by the Funds' investment activity.\textsuperscript{88}

It did not take long, however, for vested institutional interests in favor of the insurance system to appear on the horizon; one of the most dominant political players in health care is now the insurance lobby. This lobby has been the principal proponent of reform intended to further marketize and perfect the insurance system rather than scuttle it. The fundamental choice between these two courses of action, or a yet-to-be-defined third position, is the subject of legislation currently being debated in the State Duma.\textsuperscript{89}

Continued structural imbalance

Given the difficulties with conceptualization and implementation outlined above, it is not surprising that obligatory medical insurance has done little to correct the structural deficiencies which linger from the Soviet era. Hospital care continues to consume around 80\% of health care resources, and very few steps have been taken to encourage a move toward day hospitals, outpatient surgeries, free-standing diagnostic centers, and other institutions which might decrease excessive rates of hospitalization.\textsuperscript{90} One analysis demonstrates that hospital costs could be reduced by as much as 40-50\% if more rational use were made of existing intensive care facilities.\textsuperscript{91} The market alone is unlikely to cure these structural disproportions.

Hope for the Future

As heated discussion and debate about the Russian system of obligatory medical insurance continues, health reformers increasingly realize not only that insurance is an inappropriate vehicle for transition to health markets, but also that a carefully crafted combination of market forces and government regulatory policies is necessary to correct health market deficiencies and achieve socially desirable health policy objectives. Much uncertainty and ambiguity remains about some elements of the insurance system: the role and extent of competition among insurers; the role and extent of competition between and among public and private providers; and the financial and structural incentives determining providers' behavior.

But there are many positive developments to focus on as well. Insurance-based financing of the health care system has begun to stabilize, and even to rise in some regions. More and more regions
are developing computerized information systems on patients, employers, providers, insurers, and medical services and standards, completing an essential prerequisite for an efficiently functioning insurance mechanism. Some regions and insurers are beginning to understand the importance of prospective, efficiency-based incentive payment schemes, and in even more areas intensive work is being done on sophisticated quality measurement and control techniques.  

By and large, Russian health policy makers now find themselves asking questions not unfamiliar to their counterparts in the West: how can cost and utilization controls be effectively implemented in a way that will preserve an acceptable level of equity and access? How can providers' incentives be constructed such that they produce the right set of behaviors without improperly restricting physicians' freedom to make their own decisions on individual patient care? How can regulatory measures to maintain access in sparsely populated rural areas still ensure cost-effectiveness and quality of care? Where is the right balance between avoiding inappropriate and wasteful hospitalization, and dangerous denial of necessary care and premature discharge from inpatient facilities? It was probably unreasonable to expect that the first iteration of reform of such a massive system could produce defect-free results overnight. Now that several years have passed, however, it is reasonable to expect that, assuming overall economic conditions in Russia permit employers and local budgets to continue to make the legally mandated payments into the system, health insurance will evolve over time into a series of reform efforts that will serve the Russian people well.

Endnotes


7. Ryan, 1990, p. 64.


18. Isakova, et. al., 1995, p. 158.
22. See, for example, A. Telyukov and I. Sheiman, "Zarubezh'ye kak ono yest'," Meditsinskaya Gazeta, October 15, 1989, pp. 2-3; and author's conversation with Igor Sheiman, Moscow, May 21, 1997. For a negative reaction to this line of thinking, protesting that the Russia's Soviet legacy cannot be ignored, see S. Pagutochkin, "Pochemu v Sibiri ne rastet kaktusy," Meditsinskaya Gazeta, March 29, 1991, p. 4.
25. Interview with Igor Sheiman, Moscow, May 21, 1997, and with Nikolay Gerasimenko, Chair of the State Duma Committee on Health Protection, Moscow, May 19, 1997; also interview with Igor Zakharov, Chair of the Department of Economic, Health Care Management, and Health Insurance, Saratov Medical University, in Chapel Hill, North Carolina, March 24, 1997.

26. Interview with Sheiman.


28. Interview with Professor Vladimir S. Luchkevich, Professor of Social Medicine and Public Health, St. Petersburg Sanitary-Hygienic Medical Institute named for Mechnikov, St. Petersburg, June 9, 1993.


31. The term "insurance" is used broadly here to include mandatory government programs which, if compulsory in nature, are really public social security programs. Strictly defined, an insurance policy is a contract under which an individual, concerned about the risk of economic loss due to a circumstance which may or may not occur in the future, transfers that risk to an insurer who has agreed to pay a certain amount of money should that loss occur. The insurer agrees to bear all or part of the individual's risk in exchange for the routine payment of a specified fee, or premium. See Dani L. Long and Gene A. Morton, Principles of Life and Health Insurance (Atlanta: Life Management Institute LOMA), 1988, pp. 1, 225.


34. For an example of this naive thinking about the desirability of a rapid transition to medical insurance, see the roundtable discussion "Insurance-Type Health Care -- Is It a Way Out of Our Impasse?" Moskovskaya Pravda, January 30, 1991, p. 3, in JPRS-UPA-91-015, March 20, 1991, pp. 91-94.


41. A. Lastovetskiy, "Idti svoim putem ili razvivat'sya dialekticheski?" Meditsinskaya Gazeta, No. 87, November 1, 1996, p. 4; Boris A. Rozenfeld, "The Crisis of Russian Health Care and Attempts at Reform," in Julie DaVanzo, ed.,
42. Interviews with Nelli Krasnova, Deputy Director, and Albert Trauter, Director, of the Kemerovo Oblast Obligatory Medical Insurance Fund, Kemerovo, May 8, 1997; and Il'ya Lomakin-Rumyantsev, Director, Moscow City Obligatory Medical Insurance Fund, Moscow, May 21, 1997.

43. Interview with Nikolay Gerasimenko, Chair of the State Duma Committee on Health Protection, Moscow, May 19, 1997.


51. Interview with Il'ya Lomakin-Rumyantsev, Moscow, May 21, 1997.


53. Interview with Alexander A. Sviridov, Head of the Moscow Physicians' Association, Moscow, May 20, 1997. A slightly more developed payment structure has begun to develop in some parts of St. Petersburg, where physicians are paid according to the number of patients who choose them, but enrollment limits are enforced. Interview with Victor A. Lind, Executive Director, Leningrad Oblast Obligatory Medical Insurance Fund, St. Petersburg, June 27, 1995.


64. Interview with Loudmila Pronina, former consultant to the State Duma Committee on Health Protection, Moscow, May 19, 1997.


67. Interview with Dr. Arthur Rak, Department Head at the St. Petersburg Sanitary-Hygienic Medical Institute named for Mechnikov, St. Petersburg, June 9, 1993; Rozenfeld, 1996, pp. 168-169.


74. Polyakov, et. al., 1995.


80. Interview with Yuri M. Komarov, Director General, MedSocEconInform Public Health Institute, St. Petersburg, June 23, 1993; Savas and Sheiman, 1996, p. 21.


84. Interview with Dr. Valery Okulev, Immunology Department Head, St. Petersburg City Hospital Number 31, St. Petersburg, August 25, 1993.


86. Polyakov, et. al., 1995, p. 4.


92. S. Khristenko, "Garant dlya patsienta," Meditsinskaya Gazeta, No. 46, June 12, 1996, p. 7. These areas were the focus of the USAID-funded ZdravReform project carried out by Abt Associates throughout Russia in the early and mid-1990s. See "ZdravReform in Russia?" presentation by James A. Rice, former Moscow director of ZdravReform, at the University of North Carolina, Chapel Hill, March 25, 1997.
