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**TITLE: LESSONS FROM OBLIGATORY MEDICAL INSURANCE IN  
MOSCOW AND NIZHNY NOVGOROD**

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# LESSONS FROM OBLIGATORY MEDICAL INSURANCE IN MOSCOW AND NIZHNY NOVGOROD

## Abstract

The city of Moscow and the Nizhegorod Oblast are on opposite ends of the spectrum when it comes to Russia's 1993 legislation on obligatory medical insurance: Moscow enjoys a sophisticated, well-developed insurance system, while the Nizhegorod region has taken literally no steps toward implementation of the law. Despite their radically differing approaches to the market-based insurance reforms, however, Moscow and Nizhny Novgorod continue to enjoy roughly the same quality of available health care services, at similar costs to consumers. They also suffer some of the same continued systemic defects inherited from the Soviet era. A comparison of the two regions demonstrates that, while reform of the Soviet health care system was desperately needed, the Russian version of obligatory medical insurance has not proved to be the panacea its architects intended. In fact, even some its original pioneers are now moving forward with new schemes to correct some of its deficiencies.

## Introduction/Summary

In response to the disintegration of the Soviet health care system and political pressure to marketize virtually all sectors of the economy, the Russian government in 1993 passed legislation implementing a nationwide scheme of obligatory medical insurance. Based largely on existing Western European models, in particular that of the Netherlands, the new Russian system is intended to segregate a dedicated channel of health care financing from the rest of the state budget, encourage market-based efficiencies through customer choice of insurer and health care provider, and devolve authority and responsibility for medical care to the oblast level.

Employers now pay a 3.6% payroll tax for the medical insurance of their employees into non-commercial territorial health insurance Funds. Municipal governments pay into the Funds on behalf of people who do not work (students, pensioners, the unemployed, etc.) at a capitated rate negotiated separately in each oblast. The territorial Funds in turn channel money to a network of private, licensed insurance companies, who enroll participants, enforce quality control standards, and make payments to hospitals and polyclinics.

Not surprisingly, the obligatory medical insurance legislation has been implemented unevenly throughout the Russian Federation. Employers and local governments in some areas shirk their responsibility to make insurance payments to the Funds, or in many cases, simply cannot afford to pay; the market has not created the necessary number of insurance companies, particularly in rural areas; and the Funds engage in a continual political tug-of-war with local health administrators who resent their loss of bureaucratic turf and budget authority. As a result, health insurance in Russia

currently exhibits a patchwork quality, with state budgets, insurance companies, and insurance Funds combining in varying roles from oblast to oblast in funding medical care.

Because the insurance idea, however, stems from an aggressive attempt to realize the benefits of market forces in the health sector, it is reasonable to expect that the more progressive urban centers would be the trailblazers putting health insurance into effect. While this is true in most cases, the country's third largest city -- the capital of an oblast widely cited as the most economically progressive in all of Russia -- is the only one of Russia's 89 regions to have taken literally no measures to implement the health insurance law. Paradoxically, Nizhny Novgorod and the Nizhegorod Oblast have retained Soviet-style health care financing, with money going straight from the state budget to hospitals and polyclinics. Medical insurance companies have no role to play. Although a territorial medical insurance Fund has been created, it exists only to insure citizens of the Nizhegorod Oblast when they are working or travelling outside their home region.<sup>2</sup>

Moscow, on the other hand, boasts perhaps the most well-developed system of obligatory medical insurance in Russia. This paper will exploit this fundamental difference between two otherwise similar regions -- the city of Moscow and the Nizhegorod Oblast -- in an exploration of the impact and future of the insurance scheme. It will demonstrate that, despite their radically differing approaches to the market-based insurance reforms, Moscow and Nizhny Novgorod seem to enjoy roughly the same quality of available health care services, at similar costs to consumers. They also suffer some of the same continued systemic defects inherited from the Soviet era. The paper will further argue that, while reform of the Soviet health care system was desperately needed, the Russian version of obligatory medical insurance has not proved to be the panacea its architects intended; indeed, even some its original pioneers are now moving forward with new schemes to correct some of its deficiencies.

### Obligatory Medical Insurance in Moscow

The 1996 annual report of the Moscow City Fund of Obligatory Medical Insurance reveals the extent of the development of the insurance network in the capital.<sup>3</sup> As of January 1, 1997, 93.8% of the adult population and 86.6% of the child population of the city has been issued medical insurance policies, good for treatment in one of 564 city-licensed polyclinics and hospitals serviced by 45,588 participating physicians of various specialties.

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<sup>2</sup> Interview with Alexandr Vorentinovich Kartzevskiy, Director, Nizhegorod Oblast Health Department, May 16, 1997. Several residents of Nizhny Novgorod later claimed, however, that this is not the case; they routinely travel to Moscow, for example, with no insurance coverage whatsoever, despite the fact that they cannot obtain medical care in Moscow (even in the event of an emergency) without an insurance policy.

<sup>3</sup> "Godovoy otchet," Moscow City Fund of Obligatory Medical Insurance, Moscow, 1997. Many thanks to Il'ya Lomakin-Rumyantsev, Executive Director of the Fund, for providing me with a copy of this report.

In the last two years the number of employers paying into the insurance Fund has almost doubled, from 163,836 in 1994 to 326,151 in 1996. The city government also contributed to the Fund as required, resulting in the following pattern of inputs in 1996:

Insurance Payments to the Moscow City  
Obligatory Medical Insurance Fund,  
by quarter, 1996<sup>4</sup>

	<u>Taxes from employers</u> (billions of rubles)	<u>Payment from city budget</u> (billions of rubles)	<u>Total payments</u> (billions of rubles)	<u>Payments per resident</u> (thousands of rubles)
1st quarter	348.1	198.2	556.4	64.91
2nd quarter	429.2	260.1	679.3	79.25
3rd quarter	445.3	287.0	745.3	86.95
4th quarter	516.8	255.5	759.7	88.63
Total, 1996	1739.4	1000.8	2740.2	319.72

These actual collections do not represent all of the money that employers legally owed to the Fund in 1996. Employers' debts to the Fund totaled 142.9 billion rubles in that year, of which 42.6% is attributable to a relatively narrow circle of enterprises: the Moscow Metro construction company, the Moskvich and Zil automobile firms, and several defense enterprises. Of the Fund's 860 employees, about 500 are assigned to full-time tax collection duties; in 1996, their efforts resulted in the levy of 57.4 billion rubles in fines for late or inadequate payment of health insurance payroll taxes. An extensively computerized information system, containing databases on each employer, its enrollees, required payments, actual payments, fines owed/paid, and future projections, keeps track of all this activity. The city's contributions for the non-working population are similarly extensively documented.

The Fund's annual report also meticulously accounts for its expenditures on health care of the city's residents. In 1996, the Fund was responsible for medical treatment delivered to 48.3 million patients, at a total cost of 2411.9 billion rubles. Only three percent of the total number of patients was hospitalized, but hospital costs consumed almost half of the total financing. The report further documents the structure of health care costs, with extensive analysis of costs by quarter, growth rate, administrative district of the city, type of treatment facility, season of the year, various demographic factors, insurance company, and other variables. The Fund is even beginning to track subsidized payments for pharmaceuticals (mandated by law for war veterans and several other categories of

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<sup>4</sup> "Godovoy otchet," Moscow City Fund of Obligatory Medical Insurance, Moscow, 1997, page 3.

people) through the placement and scanning of bar codes on prescription drugs,<sup>5</sup> and is almost ready to complete the transition to a system of direct electronic billing of treatment facilities to insurance companies.

In other words, it is clear that obligatory medical insurance is functioning throughout Moscow. The Fund comprehensively collects the payments it is supposed to collect, and it supports a well-developed network of insurance companies through which the city's residents receive coverage. Conversations with randomly selected Muscovites support this conclusion:<sup>6</sup> when someone gets sick, he goes to his clinic, and his treatment is paid for as long as he presents his insurance policy; if he must be hospitalized, his treatment there is covered as well, as prescribed in the list of benefits contained in the Russian health insurance legislation.

### Health Care Financing in Nizhegorod Oblast

The situation is radically different in the Nizhegorod region, including its capital city of Nizhny Novgorod. Although the 3.6% payroll tax for health care needs is still collected from employers, rather than being channeled into an oblast health insurance Fund, the money goes directly into government budgets. Of these collected taxes, 25% go toward general oblast-level public health programs, while 75% is distributed directly to cities and rayons on a capitated basis.<sup>7</sup> At all levels, the tax money is combined with other resources the government allocates to public health and medicine, and the government then makes direct payments from the budget to polyclinics and hospitals. The total amount of money the government directs toward medical care is determined by the oblast parliament and city council.

According to the directors of the city and oblast health departments in Nizhny Novgorod, the region's people still receive free health care at both polyclinics and hospitals. Although they have no insurance policies, randomly surveyed residents of Nizhny Novgorod confirm that they do not have to pay out of pocket for essential treatment. Similarly, Nizhny Novgorod hospitals and clinics receive steady (if not always, in their view, adequate) funding from the budget.<sup>8</sup>

The reasons behind the Nizhegorod region's refusal to implement the obligatory medical insurance legislation remain vague. Health officials in Nizhny Novgorod deliberately lambast the federal law, claiming that the medical insurance Funds and insurance companies are useless middlemen who consume scarce resources which should be devoted directly to health care.<sup>9</sup> These

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<sup>5</sup> Interview with Nadezhda I. Sosina, Deputy Head of Pharmacy Institutions and Enterprises Department, Pharmimex Joint-Stock Company, Moscow, May 20, 1997.

<sup>6</sup> Authors' interviews, June 1995 and May 1997.

<sup>7</sup> Interview with Kartzevskiy, May 1997.

<sup>8</sup> Author's interviews with physicians, hospital administrators, and other citizens, Nizhny Novgorod, May 1997.

<sup>9</sup> Interview with Kartzevskiy, and also with Alexander Vladimirovich Smirnov, Director, Nizhny Novgorod City Department of Health Care, May 15, 1997.

officials similarly argue that Russia's demographics doom this particular insurance scheme as unworkable -- there simply are not enough young, healthy, employed individuals to make payments to offset the costs of treatment of the elderly, and therefore medical care should remain completely publicly funded. One senior physician in the region points to politics: as indicated earlier, the arrival of the Funds and insurance companies wrests away a substantial degree of the local health authorities' decision and budgetary authority; he claims that the Nizhegorod Oblast's bureaucrats prevailed in their struggle to retain power.<sup>10</sup> None of these factors, however, particularly distinguishes the Nizhegorod region from the rest of the country; whatever the solution to this mystery, it remains the case that the Nizhegorod region is unique in its retention of complete government-controlled financing of health care.

### Different Solutions; Similar Results

Despite the radically different approaches to and level of development of health care financing in Moscow and the Nizhegorod Oblast, the two locations are experiencing many of the same difficulties in their health care systems. In terms of availability of resources, medical care providers in both Moscow and Nizhny Novgorod seem to be surviving uneasily at current levels of funding and with considerable continued uncertainty about the future. In both cities, as far as clinics and hospitals are concerned, the years 1993-1994 were considerably more comfortable in budgetary terms than the present day, since the 3.6% insurance payroll tax was being collected in addition to the government contributions to health care. In these two regions, however, as well as across the rest of the Russian Federation, regional and local governments began to reason in 1994-1995 that the introduction of the payroll tax reduced their responsibility for health care financing, and they therefore began to slash health budgets, in most cases in amounts commensurate with that being contributed by the insurance tax.<sup>11</sup>

As a result, in both regions, head physicians of clinics and hospitals continue to devote a substantial percentage of their efforts to the cultivation of political favor. Since in Moscow, payments for the non-employed come from the city budget, and in Nizhny Novgorod the entire budget for health care facilities remains at the whim of local and regional government administrators, physicians often find that intense political ingratiating and lobbying is the only means by which salaries get paid on time and new equipment and capital investment obtained. In fact, head doctors in both cities describe a constant double game: if the keepers of the purse strings at the city level will not cooperate, then perhaps those at the regional or federal level will, and vice versa.

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<sup>10</sup> Interview with Yuri Ivanovich Yezhov, M.D., Deputy Director for Science, Institute of Traumatology and Orthopedics, and Deputy to Nizhegorod Oblast parliament, May 15, 1997.

<sup>11</sup> Interviews at various hospitals and clinics in Moscow and Nizhny Novgorod, May 1997.

Health care facilities in both locations are also increasingly frequently resorting to a requirement for out-of-pocket payments in order to supplement official budgets. Although physicians at all facilities stress the continued provision of "basic, essential" care to all patients free of charge, in both Moscow and Nizhny Novgorod hospitals are offering meals, private telephones, more private and/or comfortable accommodations, special nursing services, and in some cases higher-quality medications, for a sometimes substantial fee. In addition, in many instances, additional payments can purchase a move to the front of a days- or months-long queue, not only for less urgent services such as optometry and dentistry, but sometimes for essentials like heart surgery.

Most important, however, is the fact that in both the city of Moscow and the Nizhegorod region, the incentive structure governing the behaviors of clinics, hospitals, and physicians has not changed substantially from the Soviet period. Because treatment facilities under the Soviet planning system were allocated resources according to numbers of beds occupied or patients treated, the prevailing incentives encouraged inefficiency and overusage of scarce resources: hospitals, for example, benefitted financially from unnecessary overhospitalization and performance of medically unwarranted procedures on patients. The obligatory medical insurance system was designed to reverse this dynamic, with competitive pressures forcing physicians to provide more cost-effective, high-quality care. Improper, inefficient decisions on the part of physicians would cause patients, or more likely insurance companies working on behalf of patients, to choose different providers, either forcing the doctors to adopt different behaviors or driving them out of business.

Even in Moscow, however, with its highly developed system of medical insurance, this change has not taken place. Instead, rules remain in place prohibiting patients from seeking treatment in polyclinics other than the one assigned to them at their workplace or residence, and in hospitals other than those determined by residence or referral by a polyclinic physician. As a result, Moscow's insurance companies remain, to a large degree, mere accounting centers rather than real purveyors of market-based incentives, and even the most sophisticated version of Russia's obligatory medical insurance scheme provides Moscow's medical care facilities with essentially the same incentive structure as the still state-run system in Nizhny Novgorod.

Nikolay Gerasimenko, Chair of the State Duma's Committee on Health Protection, explains the rigidity of the system by citing the continued monopoly structure of clinics and hospitals: the Soviet system was built along a strict vertical hierarchy, with precisely the required number of general and specialized facilities located in each geographic region.<sup>12</sup> As a result, there is exactly one appropriate facility for each resident, for each possible illness or injury. In Altay Kray, Gerasimenko's home region, for example, there are sixty districts, and therefore sixty hospitals, each offering virtually identical quality and staffing; if a patient has a more complicated medical problem,

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<sup>12</sup> Interview with Gerasimenko, May 19, 1997.



he can consult more specialized facilities at the oblast and federal level, each increasingly unique. Competition within geographic areas, based on existing clinics and hospitals, is therefore impossible as long as there is no money to construct new, competing facilities. If this explanation persists as the prevailing political view of the structure of Russian health care, it is difficult to see how the insurance system can encourage new efficiencies through competition.

Within Moscow, however, it was initially hoped that patient choice of physician within polyclinics would at least provide some new incentives at the level of the individual doctor. In 1995, 10-15% of Muscovites changed doctors (again, within their assigned polyclinics), with far fewer doing so since then.<sup>13</sup> But the only benefit these more popular physicians received was increased workload, since they still fell -- and continue to fall -- under a system of rigidly standardized, government-determined salaries. Physicians in both Moscow and the Nizhegorod Oblast earn far less than the national average monthly wage, the ruble equivalent of around \$50/month for a newly-minted polyclinic physician, up to \$200/month for a highly skilled, hospital-based specialist, and these salaries are determined solely by level of experience and training. Administrators and head doctors alike, in both cities, speak repeatedly of the need for physicians' behaviors to be governed solely by moral incentives, by their professional concern for the well-being of their patients, and not by something so "crude" as the possibility of financial reward.<sup>14</sup>

At a limited number of hospitals, a small percentage of the salary fund is set aside for incentive payments to physicians who are judged by an institutional control commission to have worked particularly well over a given time frame -- working on a shift for several days without sleep, for example.<sup>15</sup> But these rare bonuses amount only to a small percentage increase in the established wage. Even in the handful of new, private polyclinics in Moscow, salaries are still paid according to the set scale. The head physician at one of these private clinics explains that, even though he enjoys sole authority to construct his facility's budget and is not bound by the government salary regulations, he cannot be much more flexible than the state clinics. As long his facility's income is tight and unpredictable, and the bills for public utilities and other expenses can creep up quite rapidly, he cannot afford the luxury of systematically setting aside money for incentive payments.<sup>16</sup>

Without market forces entering into the equation, control over quality of care and utilization of resources is therefore still maintained by an increasingly ineffective system of government regulations. Physicians can be fined or even fired for serious mistakes, but this is quite rare. Instead,

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<sup>13</sup> Interview with Il'ya Lomakin-Rumyantsev, May 21, 1997.

<sup>14</sup> Interviews, May 1997.

<sup>15</sup> Interview with various officials at City Children's Hospital, Nizhny Novgorod, May 16, 1997.

<sup>16</sup> Interview with Dr. Pavel Koulicov, Executive Director of the Literature Foundation Central Polyclinic, Inc., Moscow, May 20, 1997.

physicians at all levels of specialty are requalified every five years, generally through "exams" consisting of observation of their everyday work; the vast majority of physicians pass these exams with ease.

In Moscow, the insurance companies, under the supervision of the Fund, have just begun to carry out expert examinations of the volume and quality of covered medical services. These inspections, conducted both at random and at the request of patients who feel they have received less-than-adequate treatment, are carried out by physicians in either the full- or part-time employ of the insurance companies. At present, they carry two sanctions for behavior deemed to be inappropriate: non-payment for procedures considered to be overpriced or unnecessary, or fines for incorrect or inadequate care. As these expert examinations become more routinized and pervasive, if coupled with genuine patient choice and individual-level incentives for physicians, they could begin to create real and effective change in the way polyclinics and hospitals make treatment decisions.

### Is Obligatory Medical Insurance the Answer for Russia?

Given the present structure of obligatory medical insurance in Russia, however, and the fact that even in its most well-developed form it still brings many of the same results as in a region with no insurance at all, many Russian decision-makers are beginning to conclude that insurance might not ultimately provide the best structure for their country's health care financing. Even two of Russia's most ardent advocates of the insurance scheme -- Il'ya Lomakin-Rumyantsev, the Executive Director of the Moscow City Obligatory Medical Insurance Fund, and Igor Sheiman, an academic and one of the original architects of the insurance system -- complain that it was wrong for insurance to shoulder the entire burden of Russian health care finance reform.<sup>17</sup>

In particular, Russia's most progressive and creative thinkers in the field of health management have now realized that the obligatory medical insurance scheme, as implemented, has not deterred many of the same perverse incentives which governed health providers' behavior in the Soviet era -- incentives which continue to render indistinguishable in many respects such regions as Moscow and Nizhegorod, despite their radically differing degrees of implementation of the 1993 insurance legislation. For this reason, they are beginning to consider new approaches. For example, in Kemerovo Oblast, for many years one of the most innovative of Russia's regions in the area of health care structure and financing, officials are now discussing the possibility of changing and augmenting the insurance system with global budgets -- an arrangement which would limit unnecessary expenditures and discourage overtreatment by setting strict limits on annual expenditures for each clinic and hospital. These "cost and volume" contracts would result in explicit rationing of

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<sup>17</sup> Interviews, May 1997.

medical care, with allocation decisions made by regional commissions.<sup>18</sup> Of course, any rationing scheme may impinge on the guarantee of free, universal access to medical care to which Russians have become accustomed. Even though this guarantee has existed much more in theory than practice in recent years, it is uncertain whether rationing can be presented in a politically palatable form.

In sum, Russia, with all of its unique problems, is joining the United States and many other countries in a search for the optimal structure and financing of national health care. It is becoming increasingly clear that the 1993 obligatory medical insurance legislation, while an important and perhaps necessary first step, was not the ultimate solution, and that Russia will continue to grapple with these issues, and with new approaches, for the foreseeable future.

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<sup>18</sup> Interview with Igor Sheiman, Senior Health Economist, Kaiser Permanente International, Moscow, May 21, 1997; see also Nikolay Melyanchenko, Chair of the Department of Health Protection, Administration of the Kemerovo Oblast, "Kontseptual'nyye osnovy postroyeniya v Rossiskoy Federatsii modeli gosudarstvennogo meditsinskogo strakhovaniya," Meditsinskiy Vestnik, No. 5-6 (72-73), March 1-15, 1997, p. 15-18.