UpDate

INTERNATIONAL REPORT

Health Care Financing Reform In Russia And Ukraine

by George J. Schieber

In this UpDate I report on the status of health care financing reform in Russia and Ukraine since the dissolution of the Soviet Union. After summarizing the previous system, I discuss the health care financing and delivery systems of Russia and Ukraine in terms of expenditures, availability and use of services, and health care outcomes. I then describe the health insurance reforms under way in Russia and Ukraine and enumerate the obstacles to reform.

Soviet Health Care System

Under the health care financing and delivery system of the former Soviet Union, which has been described in detail elsewhere, all Soviet citizens were entitled to free medical care.[1] Prior to 1987 all decisions concerning the health care system were carried out by the Soviet Union–level Ministry of Health. In concept, the system developed as a highly integrated network of polyclinics, hospitals, pharmacies, and sanatoriums.[2] Physicians and other medical workers practicing in polyclinics and hospitals were government employees. All individuals were assigned to a general practitioner or pediatrician based in a polyclinic; in rural areas nonphysician practitioners called feldshers were the first source of contact. These practitioners then referred patients to polyclinic-based specialists and to local, regional, and national hospitals and sanatoriums.

Private practice did not exist prior to 1987. There was no distinction between financing and provision since all facilities were publicly owned and all medical personnel were employed by the state. The Union Ministry of Health determined the budget and relied heavily on quantitative production norms such as numbers of facilities, practitioners, and hospital bed days of care. Equipment was allocated to republic Ministries of Health and through them to regional and local facilities.

Political changes in 1987 decentralized management of the health care system, with the republics assuming primary responsibility for managing the financing and delivery of care. Nevertheless, deviations from the Union-level spending plans were relatively small.

When the Soviet Union dissolved in late 1991, the republics received real power and control, along with taxing authority. Now, while republics still control overall policy and the legal and regulatory structures, both the financing and provision of care have been decentralized to the regional and local levels.

Russian And Ukrainian Health Care Systems

Exhibit 1 provides data on expenditures, availability and use of services, health outcomes, and causes of death for Russia and Ukraine relative to Organization for Economic Cooperation and Development (OECD) countries. Russia spends 3 percent of its gross domestic product (GDP) on

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Exhibit 1
Health System Statistics, Organization For Economic Cooperation And Development (OECD) Average, United States, Russia, And Ukraine, 1990

	OECD average	U.S.	Russia	Ukraine
Health-to-GDP ratio	7.6%	12.1%	3.0%[a]	2.7%
Public share of health spending	74%	42%	95%[a]	98%
Beds per thousand	9.1	4.8	13.8	13.0
Inpatient days per person	2.7	1.2	3.7	4.0
Admission rate (percent of population)	16.3%	13.7%	22.8%	24.3%
Average length-of-stay (days)	15.6	9.1	16.6	16.4
Occupancy rate (percent of beds)	79.6%	69.5%	79.8%	91.2%
Physicians per thousand	2.4	2.3	4.7	3.9
Physician contacts per person	6.1	5.5	9.5	9.7
Infant mortality (deaths per thousand live births)	7.4	9.1	17.4	12.8
Life expectancy at birth for males (years)	72.6	72.0	63.9	65.9
Life expectancy at birth for females (years)	78.9	78.8	74.3	75.0
Crude death rate per thousand	9.3	8.6	11.2	12.1
Crude birth rate per thousand	13.0	16.7	13.4	12.7
Population age 65 and older (percent)	13.0%	12.6%	10.1%	12.3%

Sources: G.J. Schieber, J.P. Poullier, and L.M. Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Data Update," *Health Care Financing Review* (Summer 1992); Russian Federation Ministry of Health; and Ukrainian Ministry of Health.
Notes: Figures are for 1990, or most recently available year. GDP is gross domestic product.
[a]1991.

health care, and Ukraine spends 2.7 percent, compared with an average of 7.6 percent for the OECD countries and 12.1 percent for the United States. Approximately 95 percent of Russian spending and 98 percent of Ukrainian spending are public compared with 74 percent in the OECD countries and 42 percent in the United States.[3]

Despite the relatively low spending for health by OECD standards, use and availability of hospital beds and physicians in Russia and Ukraine far exceed those of most OECD countries. This reflects the perverse incentives built into the traditional budgetary process, which relied less on health needs and outcomes and more on measurable production inputs.

Health outcomes in Russia and Ukraine compare poorly to those in OECD countries, however, despite greater availability and use of physicians and hospitals. The Russian infant mortality rate of 17.4 deaths per thousand births is double the OECD average and the U.S. rate; the Ukrainian rate is 50 percent higher.[4] Life expectancy at birth for both males and females is lower in Russia and Ukraine than either the OECD average or the U.S. rate. Crude birth rates in Russia and Ukraine are similar to the OECD average but below the U.S. rate. Crude death rates in Russia and Ukraine are 20–30 percent above both the OECD average and the U.S. rate.[5]

Reforms In The Two Republics

Ukraine and Russia are at different stages in the process of reforming their health systems, although their objectives are similar. Russia passed legislation in June 1991 establishing a health insurance law with implementation scheduled for 1993. Ukraine is developing a similar health insurance law, which will be submitted to Parliament in 1993.

Russia. The health insurance law passed in June 1991 by the Supreme Soviet of the Russian Federation mandates universal medical insurance coverage and freedom of choice concerning insurers and medical care providers. The law has two purposes: (1) to provide additional nonbudget revenue for the health sector through the establishment of health insurance funds; and (2) to encourage efficiency by separating health care financing from provision of care. Insurance funds will contract with medical care providers, and efficiency will be realized through the use of incentive-based medical care provider payment mechanisms by the insurance funds.

This plan includes both compulsory and voluntary insurance. All individuals will be covered by compulsory medical insurance, which will be financed by both enterprises and government. Enterprises will make contributions for medical insurance for their workers. All individuals not covered by enterprises (for example, dependents, the poor, the unemployed, and the disabled) will receive medical insurance financed by government. Enterprises and individuals may purchase voluntary insurance to supplement their compulsory health insurance benefits.

Most of the responsibility for financing care will rest at the regional and local levels. Individual insurers will contract with medical care providers. The republic-level Ministries of Health will retain functions such as training, science and research, public health activities (such as addressing tuberculosis, mental illness, alcoholism, and other public health threats), disaster relief, and construction and purchase of major medical equipment. Under compulsory insurance, governmental bodies and enterprises, not individuals, will choose the insurer. Individuals and enterprises purchasing voluntary insurance will choose their own insurers. Some enterprises likely will provide their workers with voluntary insurance benefits to attract and retain their work force.

Although the law was passed nearly two years ago and is scheduled for implementation in 1993, various government ministries disagree over the specifications of the final system.[6] One especially controversial provision of the law is the apparent requirement that the government and enterprises purchase risk-based commercial insurance.

Some are concerned that the requirement to purchase risk-based insurance will result in many of the risk selection problems that are rampant in the U.S. system. Such a system would allow enterprises and insurers to reap substantial profits through favorable risk selection and thus undermine the principles of social solidarity underlying both the old system and the reformed system. As a result of this controversy, in December 1992 an interministry working group on health-sector reform recommended that the health insurance law be amended to establish Social Security–type funds in lieu of risk-based commercial insurance. While the details of this approach are still under development, one proposal under consideration is to have these Social Security–type funds distribute premiums based on risk-adjusted capitation to local public and private, proprietary, and nonprofit insurance funds. This approach, by pooling all funds at the regional level and giving individual insurers a risk-adjusted capitation payment, retains solidarity and eliminates the potential for favorable risk selection on the part of local insurers. Various permutations of this approach are also being considered, including having consumers instead of employers and the state make the final choice of insurer (as in the proposed reforms in the Netherlands) or simply having the regional funds and their local branches contract directly with providers.

There are also financing and intergovernmental fiscal issues to consider. The current economic situation and inflation rate make it difficult for government to continue funding health care at current levels. The steep decline in GDP and the persistent demands of the health sector because of past underfunding have created a difficult financial situation for governments at all levels. A related problem concerns the contributions of enterprises, which were to provide additional funding for the health sector. Given the state of the economy, few enterprises can afford to make such contributions. Moreover, enterprises currently pay a 38

percent tax on payroll for pensions and for disability and unemployment insurance. The additional estimated ten to eleven percentage points of payroll tax to finance health insurance is not feasible. One proposal is to maintain the 38 percent rate but to allocate ten to eleven percentage points of that rate for health insurance rather than pensions, since the pension fund is running a surplus. Although this proposal is highly controversial, it appears to be one potential source of funding for health insurance at the enterprise level.

Russian President Boris Yeltsin delegated to the regions and territories responsibility for compulsory insurance and the right to establish contribution rates. Considering that currently approximately 95 percent of the revenues used to support the health system go directly to the regions, it is clear that from both a revenue and an allocation perspective, the region is the principal level of importance in medical insurance reform. Several regions, including Kemerovo (in Siberia) and St. Petersburg, have already implemented variants of the medical insurance reforms, including such features as partial capitation of primary care providers and diagnosis-based payments to hospitals. These regions could serve as models for the rest of the republic.

Regions and localities will need to finance their health insurance systems and most public health activities with a variety of taxes, including a value-added tax, a corporate profits tax, and an individual income tax. These taxes are generally shared among the central, regional, and local governments with the rates dedicated to different levels of government as specified in the law with little flexibility for supplementation. This rigid intergovernmental fiscal structure, in which fiscal responsibilities and revenue-raising potential bear little relationship, has created major fiscal problems for regional and local governments. These problems have been exacerbated as the national government struggles to control its budget deficit and achieve macroeconomic stability by continually shifting down health and other social safety-net fiscal responsibilities to regional and local governments without providing additional authority to raise revenues.

Another important aspect of these reforms is their impact on the private sector, including both private insurance and private provision of health care. It is difficult to predict how the private sector will develop, because of the state of the economy and a lack of laws and regulations concerning private ownership and operation of private-sector enterprises. Laws are being developed in Parliament in a wide variety of areas, many of which will have an important impact on the development of private health insurance and the private practice of medicine. While private insurance and private practice of medicine are not specifically forbidden, the absence of specific laws and regulations retards their development. Capital markets are not well developed, and the lack of a clear legal system adds to the riskiness of such ventures. The current inflationary situation engendered by partial price liberalization is placing major strains on government budgets and adds further uncertainty to private investment decisions.

In both Russia and Ukraine, a change in consumers' and providers' mentalities must precede successful transition to an incentive-based health care system. Because all citizens expect to receive free medical care provided by the state, individuals feel little sense of personal responsibility either for their own health or for their use of medical services. Similarly, salaried public employees (whether hospital administrators, physicians, or nurses) accustomed to guaranteed incomes and employment have no experience in reacting to market-based incentives to improve efficiency. Overcoming seventy years of state responsibility and replacing it with appropriate incentive-based behavioral responses by individuals is one of the most difficult challenges facing reformers.

Ukraine. The Ukrainian Parliamentary Committee on Health and the Ministry of Health have been working for the past year and a half to develop laws to reform the health care system. Two major statutory changes are being developed: (1) a statement of principles, legal rights, and the organization of medicine; and (2) a law on

health care finance designed to move from global budgeting to more modern health insurance principles and practices. The first law is needed to amend the constitution, which currently guarantees free care as a right, as well as to provide a new, more decentralized infrastructure for the organization of medical practice. The second law provides for the establishment of both compulsory and voluntary medical insurance funds.

While the health insurance law has not been finalized, a draft has been developed. As in Russia, the basic principle is to move to a system operating on modern insurance principles and market forces. Financing and provision of care will be separate. The law will create a compulsory insurance program and authorize voluntary insurance, which likely will provide supplementary benefits.

As currently envisaged, compulsory insurance initially will be under the control of the Ukrainian Ministry of Health but will transfer to an autonomous fund over time. Regional and local branches of the funds will be established, but each will be a monopoly. For reasons of administration and solidarity, funds will not compete. However, both public and private entities can buy in to the regional and local health insurance funds. Financing for compulsory insurance will be provided by enterprises for their employees and by the state for everyone else. As currently proposed, enterprises will pay risk-adjusted premiums for their employees. In addition to compulsory health insurance contributions for those not in enterprises, government will be responsible for public health activities, administrative expenses, capital expenditures, and fiscal equalization for poor regions.

The Ministry of Health anticipates submission of the initial draft to Parliament in 1993, although there is no fixed schedule for adoption and implementation, because of a large backlog of pending legislation. The ministry intends to establish a pilot project for the proposed compulsory medical insurance system.

There also has been a good deal of reform activity in the private sector. Despite the ambiguities of the current legal structure, there are several efforts to establish local market-oriented private health insurance companies and private medical practices. As in Russia, these efforts are constrained by the absence of laws that support privatization and by a lack of technical knowledge and managerial capacity. While private health insurance and private medical practice are not illegal, the ambiguous legal and regulatory base and the uncertainty of payment arrangements create constraints to their development.

Obstacles To Reform

The potential for success of these reforms in both Russia and Ukraine depends on economic recovery; establishment of legal and regulatory structures concerning privatization, financial markets, price liberalization, and decentralization; and obtaining needed technical assistance. Most importantly, health care financing reform requires a stable and growing economy in which both government and enterprises have the funds needed to support the health care system. With GDP falling in real terms in both countries, government lacks the fiscal ability to support the system at its current levels; nor do enterprises have the ability to pay increased payroll taxes to buy health insurance for their workers. In addition, foreign exchange is not available to buy desperately needed medicines, supplies, and equipment. The rapid dissolution of the Soviet Union has seriously interfered with both production and trade across republics. Clearly, economic recovery and cooperation are needed to reverse these disastrous trends.

A second set of factors retarding health care reform and the introduction of market forces into these health systems relates to the uncertainty resulting from the absence of legal structures concerning private ownership, financial markets, and the decentralization of the health system. The erratic pace of price liberalization and the inflation accompanying it add further to this uncertainty. Until there are clear rules regarding private ownership; until financial markets develop; until the ownership status of public

hospitals, polyclinics, and pharmacies is clarified; and until price controls are lifted, the development of a private sector in insurance and service provision will be retarded. Moreover, market incentives cannot be expected to be effective unless price signals correspond to real resource costs. Without price liberalization, market signals will be misleading and will not result in efficient resource allocation.

Finally, Russia, Ukraine, and the other republics of the former Soviet Union will need significant technical assistance. As enumerated previously, technical assistance in establishing and regulating health insurance, developing accounting and management information systems, establishing incentive-based provider payment systems, implementing quality assurance systems in hospitals and polyclinics, and the whole realm of "operations improvements" at the individual institution level is needed.[7]

While this UpDate has focused on the financing of health care, there are also pressing needs for assistance in the areas of pharmaceutical and vaccine production, supplies, medical education, and infrastructure development. Furthermore, while outside assistance is needed in the short term, over the longer term it will be essential to build the capacity of indigenous institutions to address these areas. It is hoped that governmental and international assistance agencies will take on this challenge in a coordinated and effective manner.

The views expressed in this paper are those of the author and do not necessarily reflect those of the Health Care Financing Administration.

NOTES

1. A. Robbins et al., "Financing Health Care in the New Soviet Economy," *Journal of the American Medical Association* (5 September 1990): 1097–1098; D. Rowland and A. Telyukov, "Soviet Health Care from Two Perspectives," *Health Affairs* (Fall 1991): 71–86; I. Sheiman, "Health Care Reform in the Russian Federation," *Health Policy* 19 (1991): 45–54; and D. Schultz and M. Rafferty, "Soviet Health Care and *Perestroika*," *American Journal of Public Health* (February 1990): 193–197.
2. In fact, there were actually three levels of care in the Soviet Union. The political elite—an estimated 2 percent of the population—had a closed system of hospitals and polyclinics for themselves and their dependents. A second tier was and still is a system of hospitals and facilities run by individual enterprises and key government ministries such as Defense and the KGB. The third tier served the general citizenry.
3. If black-market activities, other private health expenditures, and certain omitted health care expenditures by enterprises are included in health expenditures, the public share would be significantly reduced, perhaps to a level of 80 percent, and the health-to-GDP ratios would be increased, perhaps on the order of 20 percent. See I. Sheiman, "State Tax-Financed or Health Insurance Model? A Difficult Choice to Be Made in Russia" (Discussion paper presented at York University, United Kingdom, March 1992).
4. The infant mortality rates for both Russia and Ukraine are significantly understated because infants born with certain gestation, weight, and size limits are excluded from the definition of live births.
5. It should be pointed out, however, that the vital statistics of both Russia and Ukraine compare quite favorably with those of other middle-income countries.
6. With the exception of those areas currently experimenting with medical insurance reforms, "implementation" at any time in the near future is likely to mean continuance of the present system, since the requisite insurance institutions are not in place. Moreover, in the current economic climate most enterprises will be unable to pay additional taxes for health insurance coverage of their employees. D. Chernichovsky, "A Right to Health Insurance versus a Right to Health Care: A Critique and Amendment Proposals—The Health Insurance Law of the Russian Federation" (Paper prepared for the World Bank, Moscow, 22 September 1992).
7. G.J. Schieber and J.C. Langenbrunner, "Obstacles to Soviet Health Reform," *Health Affairs* (Winter 1991): 312–314.