COMMERCIALIZATION OF MEDICAL CARE AND HOUSEHOLD BEHAVIOR IN TRANSITIONAL RUSSIA

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Abstract

This paper investigates the patterns of Russia's out-of-pocket household expenditure on health care using the household and individual data of Rounds 5 to 9 of the Russia Longitudinal Monitoring Survey covering the period of 1994-2000. Over this period, total household monthly expenditure on health care had grown slowly in real terms by about one-third. On average, households were spending about three percent of their income on prescribed drugs and medical services in 1994-1998. In 2000, this percentage suddenly grew to twelve percent due mainly to a drop in the average reported monthly household real income. Most of the household money spent on medical services went to the public medical care system for services that were supposed to be provided for free. The burden of out-of-pocket expenditure was income-regressive. While the households from the top income quintile were spending about two times more in absolute terms than the households from the bottom income quintile, in relative terms, they were spending about ten times less share of their income than the bottom quintile households. Our results, in general, comply with findings of other research that were based on surveys of treatment facilities, and other household data. We conclude that the level of out-of pocket expenditures is substantial and growing, and that the development of a shadow market for publicly provided medical services worsens the population differentiation with respect to the ability to receive high-quality health services.

I. Introduction

The development of a shadow market for publicly provided medical services worsens the population differentiation with respect to the ability to receive high-quality health services. In order to neutralize the negative effects while keeping in place some economic motivation for health care providers, an explicit acknowledgement by the government of the paid character of public health care is needed.

The existence and extent of shadow commercialization in Russia's public medical care system have been studied by several authors (Boikov et al., 1998; Satarov, 2001; Shishkin, 1999; Shishkin et al., 2002). This paper presents a demand-side view on the problem using the household data of the Russia Longitudinal Monitoring Survey. Where it is appropriate, our findings are compared with findings by other authors.

The following section presents a summary of expert views on the causes of the tendency towards shadow commercialization in Russia's public health care system. Section III describes the data set. Section IV analyzes the contribution of private medical care providers and private insurance suppliers to the overall commercialization of Russia's health care sector. Section V describes the patterns of household out-of-pocket expenditure on health care including the expenditures on drugs and medications, outpatient treatment, and inpatient treatment in public health care facilities. In Section VI, we present the results of two logit regressions that determine which household and individual characteristics have a statistically significant influence on the decision by a household or an individual to spend extra money on health care. Section VII concludes the paper.

II. Causes of shadow commercialization

There are two most often sited causes of the tendency towards shadow commercialization in Russia's public health care system. First, the system has not been properly financed from public sources since the time of its creation in the early 1990-s. Persisting overall under-financing from public sources forces patients to compensate health care providers with their own money. Second, the current system does not provide for proper incentives when health care providers interact with the patients. By paying out-of-pocket, patients introduce some kind of economic motivation in order to obtain a guarantee of "quality".

Overall underfinancing

The new Russian State inherited the Soviet-era constitutional guarantees of free high-quality public health care. These guarantees have proven to be too ambitious and at the same time too vague. The misbalance between the declared state guarantees and their funding has been causing a stable deficit at all level of public financing of health care. Figure 1 provides a typical picture using the 2000 data. Since no clear distinction has been made between the responsibilities of the federal and regional budgets, the federal and regional funds for Mandatory Medical Insurance (MMI), and private providers of medical services, it is not even possible to get the precise figure of the overall deficit in the public health care financing. Different experts provide different estimates varying from 11-25% (Shishkin 2000) to 40-65% (Makarova 2000).

From 1991 through 1998, when the federal budget experienced chronic deficits, public spending on health care shrank by 33 percent in comparable terms, while government guarantees of free medical care to citizens remained unchanged (Dmitriev et al, 1999). Even in recent years of stable budget surpluses, President Vladimir Putin calls the government financing of its social obligations "unacceptable" (*"Vedomosti,"* Feb. 20, 2003). The total annual social obligations of Russian governments at all its levels (federal, regional, local)

constitute 6,5 trillion rubles while their total consolidated budget does not exceed 3,5 trillion rubles. While the situation with government spending on health services is less dramatic than one with spending on culture and education, the funding is still too low to support the existing network of medical institutions.

The continuous misbalance between the volumes of federal guarantees for free health services and effective federal funding for these purposes was the main reason for the development of a shadow market in this sector.

MMI employers' contributions: disincentives to pay

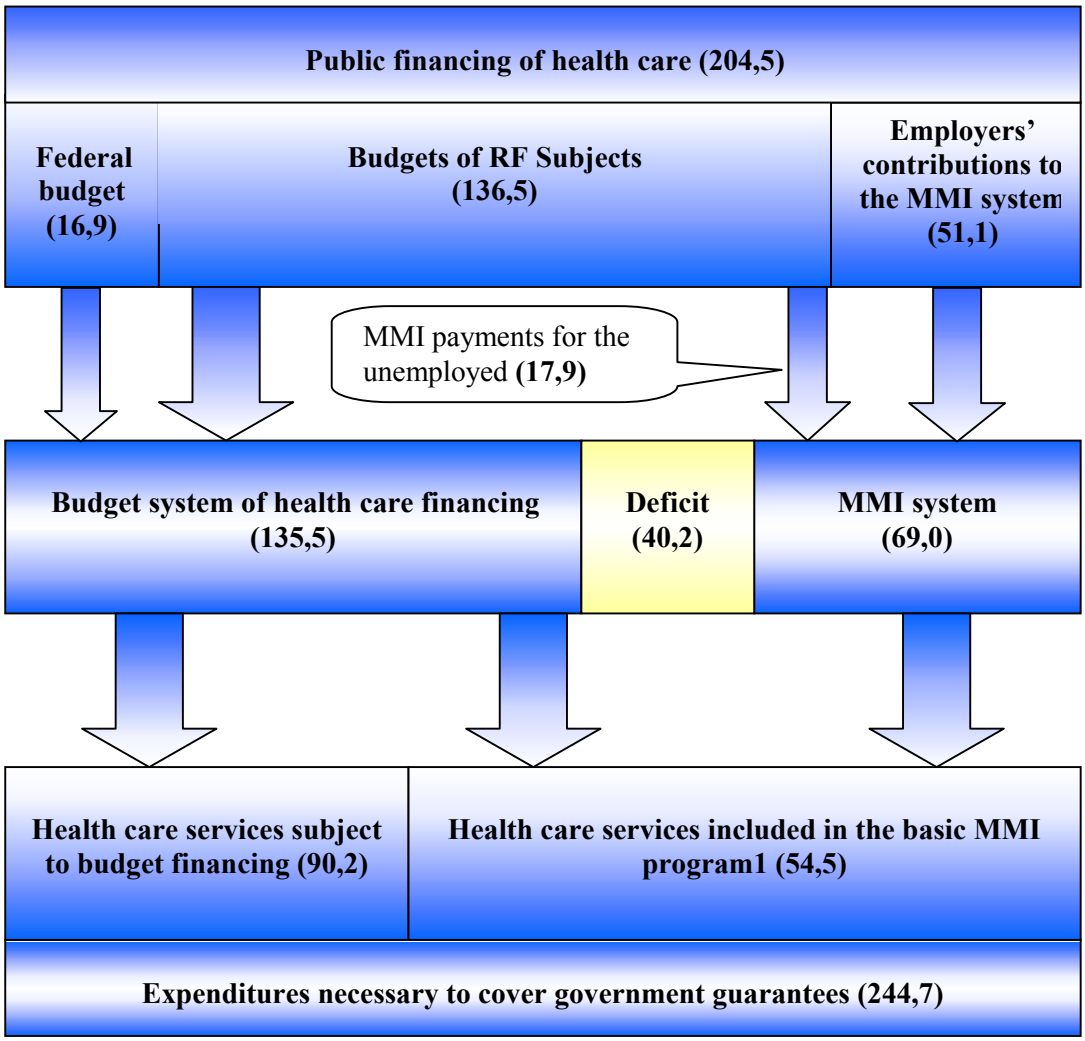
Mandatory medical insurance territorial funds should accumulate employers' contributions to the MMI system on behalf of their employees. In reality, payments are made in such amounts that are insufficient for funding the MMI programs. On average, MMI funds accumulate only about one-third of the costs of a basic MMI program (Dmitriev et al, 1999, and Figure 1).

The MMI contributions constitute a smaller part of the Unified Social Tax, which also includes contributions to the Pension Fund of Russian Federation and to the Social Insurance Fund of Russian Federation. Out of the 35.6% tax rate, only 3.4% go to a regional MMI fund that finances the services of a public health care facility to which a given employee is assigned (0.2% that go to the federal fund are used to compensate for inter-regional differences). There is no clear connection between the volumes of contributions and the volumes of the public services provided. Today's effective average rate of the Unified Social Tax is about 30 - 32% of a firm's total employment compensation fund, and businesses consider it excessive. Hence, there exists a widespread practice of shadow employment compensation that accounts for one-third of the total labor bill, and the *de-facto* effective average rate of the Unified Social Tax is estimated at only 20 - 22% (*"Vedomosti,"* Feb 11, 2003). Moreover, millions of self-employed persons do not pay this tax.

A peculiar equilibrium arises. While the MMI contributions that are meant for employed citizens seem to be insufficient to fully finance the public medical care as should be provided for such insured (Shishkin 2000), the contributors have strong incentives to minimize even these insufficient payments.

Figure 1

Deficient public financing of health care in Russia
(2000, billion rubles)



Source: Shishkin et al (2002)

Political struggles over compensation for non-working citizens

At present, the MMI payments compensating for the unemployed are provided at the expense of local and regional budgets. Numerous eclectic regional schemes for funding medical care have arisen, based on very diverse regional taxation systems. These schemes involve large-scale substitution for government financing by private businesses mostly in the form of shadow or quasi-formal payments to regional governments and, sometimes, directly to medical institutions. The federal government stipulates that coverage is to be universal, and is supposed to pay matching contributions to regional budgets in order to ensure "federal entitlements". The matching contributions have become an object of many political struggles between the levels of the government. Irregular financing by the federal government of its over-stated health care guarantees creates incentives for regional governments to blame all regional health care system problems on the lack of federal funding for such guarantees.

The tax reform of 2000-02 has drastically reduced the share of regional budgets in the total tax revenues from 54% in 1999 to 40% in 2002 (Yasin 2002). At the same time, the compensating transfers from the federal center have been of a general nature, not assigned to a particular program task. In such conditions, regional health authorities have experienced a lack of funds to finance their health care obligations.

In April 2003, the government has decided that the public medical services to the unemployed will be compensated from the Federal Pension Fund according to the standards that are soon to be defined. From the long-run viewpoint, the involvement of the Federal Pension Fund in the financing of the health care is very natural since it is a step to the creation of a transparent unified publicly financed social insurance system with clearly defined government guarantees. However, in the short run it worsens the current non-transparent situation where several independent government bodies on the federal and regional levels are responsible for the provision of the same public guarantees. These short-run measures are clearly a result of the political pressure of regional governments, who seek to get some control over the financial resources of the Federal Pension Fund.

Private insurance companies: hopes unfulfilled

A shift from the budgetary system of financing to the MMI system was the pivot of Russia's health services reform in the 1990-s. A peculiarity of the Russian MMI system is that two types of entities may perform the role of insurance carriers: private health insurance companies and branches of territorial MMI funds. All versions of the Russian Federation Health Development Concept adopted in the 1990-s implied that private insurers should be responsible for health care purchasing for the MM system, while MMI funds' branches might act as substitute insurers only in remote low-populated areas.

While introduction of medical insurance in early 1990-s was viewed primarily as a means of obtaining guaranteed sources of financing, there was another important goal declared, i.e., to create incentives for quality and efficiency of publicly provided medical services. The need for such incentives has been continuously expressed in population polls during the years of the reform. For instance, Ordina et al (1997) report that 85 percent of the respondents accepted the concept of paid health care if such incentives were created. The idea was to introduce institutional separation of those who provide medical services from those who pay for them. The competition between medical service providers for receiving finance was supposed to emerge. The insurance companies were also expected to compete for contracting citizens' money, and act as intermediaries between citizens and medical institutions. Hence, patients' right to choose the doctor, medical institution, and intermediary was to be ensured within the public health care system as well as within the private one.

In the 1990-s, when the federal government was steadily violating its obligations to finance health care, and per capita rates at which insurers were funded did not suffice to cover medical costs of benefit plans promised to the insured, the insurance companies survived by transforming their role. In spite of the original intent of the system creators, no visible competition between insurers was achieved. In the majority of cases, regional health authorities did not support the idea of insurers' involvement in health care planning, as they believed it was their prerogative. Regional and local government agencies often forced insurers to contract treatment facilities under their administration in order to keep them running regardless of quality and effectiveness of care they provided. The insurers became simple translators of cash flows. They strove to receive more funds at their disposal and live on their commissions (supposed to cover costs of administration) and profit on legal and illegal short-term investments of spare cash. An optimization of health care structure and higher efficiency of resources' utilization through sophisticated management of patient and cash flows could be hardly seen in their activities. Formal terms of contracts entered into by an insurer, an insured, and a medical institution were, to a great extent, supplemented with informal terms and agreements that involve regional authorities. Many regional authorities argued that operational costs of insurance companies were too high, while their efficacy was doubtful, and chose to eliminate private insurers from their territorial MMI systems completely.

The involvement of private insurers in the MMI system, therefore, has not built a quality-enhancing incentive link between the patient and the health care provider, thus, creating an opportunity for under-the-counter deals.

Inflexible financing of health-care providing facilities

In the 1990-s, public health care providers were transformed from budget organizations into treatment-providing facilities, i.e., state enterprises with no autonomy to manage the resources but with some additional tax liabilities. Federal priorities and requirements to the payment system from a financing party (a regional government or/and a territorial MMI fund) to a treatment-providing facility were poorly specified from the start. In practice, the design of new payment methods was left to the discretion of regional authorities. In most of the payment schemes introduced instead of or along with the former simple line-up budgets, it was the sick patient who was chosen as the basis for costs' calculation. Thus, introduction of new methods usually created perverse incentives making providers economically interested in sick, not healthy patients. For instance, the prevention services listed in the basic MMI package are paid dozens, hundreds times less than therapeutic, surgical and other interventions for critically ill patients or confirmed invalids (Makarova 2000).

Labor remuneration practices in health care providing facilities

An important cause of the shadow commercialization in the Russian public health care

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