

Health Insurance Reform in the NIS

By Alexander Telyukov, PhD, and Marty Makinen, PhD

When Americans think of health insurance, they refer first to the system of private, voluntary health insurance paid for mainly by employers--or in some cases shared by employees--where workers and dependents are covered by insurance companies for a specified set of health services. Yet this traditional reimbursement system is being replaced by negotiated fees, reimbursement that is determined on a case-by-case basis, and fixed--or capitation--payments made on a regular basis regardless of illness through a variety of managed care arrangements.

By contrast, health insurance in the NIS is viewed as a mechanism beyond general government budget allocations used for raising additional resources for health services. In this system, employers must participate in a mandatory insurance program and pay a specified percent of payroll into a common fund. Governments contribute to the same fund on behalf of nonworking people. A single, nearly comprehensive benefits package is offered to all individuals, regardless of the contribution made on their behalf.

Historically, the Soviet Union upheld a covenant with its citizens to provide universal access to comprehensive health care. This covenant was both praised for its commitment to socially just principles, and criticized for its inefficient command-and-control planning, inadequate allocation of resources, and unfair rationing of care. In the late 1980s, policy makers and citizens began to openly discuss the widening gap between the social promise of universal care and the reality of a health system constrained by scarce resources and insufficient incentives for high quality care. A health care reform debate soon emerged, and local health care delivery experiments began.

Clear goals for national health reform were first articulated in 1990 and 1991. An insurance-based mechanism of allocating funds would supplement insufficient health care financing; decentralized management would make decision-making more responsive to local needs and strengthen mechanisms to ensure compliance with reforms; and competitive contracting and performance-based reimbursement would create incentives for providers to increase the supply of services while encouraging cost-consciousness.

Russia's current health insurance system is based on the Health Insurance Act, passed in 1991 and amended in 1993. The act mandates that Russia's entire population receive comprehensive health coverage financed from a payroll tax levied on employers to cover their employees and from budget premiums that are allocated for government employees and nonworking populations. Contributions from both sources are then pooled into mandatory health insurance (MHI) funds, which pay accredited health care facilities through contracts to provide required health care benefits to patients. These funds pay subsidiaries or nonprofit insurance companies an age/sex-adjusted capitation rate, multiplied by the number of subscribers. In turn, these organizations underwrite groups for coverage and reimburse and monitor health care providers.

The Russian health insurance system--which is defined by the presence of comprehensive coverage and the absence of experience rating--can be compared most clearly to the Canadian system. Other NIS countries are at different stages of health policy reform. The Russia model was adopted, with some modifications, in Kyrgyzstan in 1993, and in Kazakstan in 1995. Health insurance legislation in these countries focuses more on financing issues than aspects of service delivery reform. In Ukraine and Moldova, health policy deliberations are still underway.

As the NIS economies improve, payrolls and government tax revenues will grow, and with them, contributions to MHI funds. This will help alleviate the resource scarcity that has

plagued providers, but problems will likely persist for three reasons. First, no mechanism constrains the MHI basic benefits package's scope. As more resources become available, providers are likely to add to the scope of services, particularly technology-intensive services. Second, provider payment reforms have introduced few incentives for efficiency. Finally, the preponderance of hospitals and specialist physicians will impede efforts to shift the system's emphasis toward primary care.

The creation of MHI funds represents a revolutionary step toward separating health financing from service delivery in Russia and elsewhere in the NIS. However, there are still many gains to be made in implementing performance-based provider payment systems. Currently, providers have only limited need to be responsive to consumers and insurers, since the latter have few choices, and MHI funds rarely exclude providers from eligibility for payment. Though insurance is in operation, many providers still receive the bulk of their revenues from government budget allocations.

The introduction of performance-based pay for providers would greatly enhance insurance reforms already accomplished. However, greater autonomy of management, training reforms and service delivery restructuring are also needed. In the years ahead, policy-makers, providers and consumers will demand modifications in health insurance. The results of the reforms already put into place in Russia and elsewhere will determine the parameters for ongoing debate, and political and economic realities will continue to dictate the terms of those debates.

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