

**The Interdepartmental Action Programme on Privatization, Restructuring
and Economic Democracy**

**The promotion and privatization of medical services in
the Russian Federation, Ukraine and Georgia**

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Note: Working Papers are preliminary documents circulated informally in a limited number of copies mainly to stimulate discussion and critical comments.

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Preface

This report was prepared on the basis of three separate country studies by national consultants. These deal with the privatization of social services, but health care in particular and the potential for setting up group health insurance schemes — in the Russian Federation, Ukraine and Georgia. Health service issues were given priority because the ILO's Mutual (Cooperative) Insurance Programme will initially operate only in this sector. The reports were designed as preparatory discussion documents to assist in launching the "Eastern portion" of the Interregional Programme "Development of the Social Economy to Combat Poverty and Social Exclusion". They have been included in the framework of the ILO's Action Programme on Privatization, Restructuring and Economic Democracy as preliminary discussion papers. The Georgian model of health management, regarded as an interesting experiment, was also discussed by the World Health Organization at the European Conference on Health Reforms held in June 1996 in Ljubljana.

This report and its supporting documents offer a socio-economic and institutional feasibility review that can help in discussing the creation and running of non-state systems of medical insurance. Topics covered include: the economic basis for ensuring social guarantees; the existing system of social protection for the population; strategy and specifics of state regulation and legislation; and the main direction and priorities for reforming health systems in these countries.

Special attention was paid to the way existing medical insurance systems work and how to reform them. Medical safety net systems were analysed as a separate issue and the main supporting pieces of legislation were also examined, as well as the mechanisms governing these. Considerable attention was paid to voluntary social insurance systems and to non-state insurance organizations. In the documents, official statistical and analytical materials are quoted, as well as scientific studies by national and foreign consultants. On the basis of the investigations carried out, conclusions and proposals for organizing mutual assistance companies are put forward together with a set of suggestions needed to help bring ILO projects to fruition.

This report also places the privatization process for medical services in its appropriate social, political and economic context and describes the main tendencies governing the evolution of this context.

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Introduction

Privatization is a major component of health system reform in the former Union of Soviet Social Republics. In creating the legal basis for the new health system, the other key elements of health reform are decentralization and a shift towards basic principles of health insurance.

A broad frame of reference must be adopted that considers privatization any measure of state disengagement from public health institutions both in terms of tutelage or in terms of management of operating health structures and financial responsibility.

Under this broad notion of privatization, government can encourage business, community groups, cooperatives, private voluntary associations and other non-governmental organizations to offer a wide range of services or participate with them in doing so. Health insurance privatization can also be regarded as a shift of responsibility to the individuals covered.

Given the specific nature of this activity social intervention is decisive both for tutelage and for financial management. What is occurring is not only a "direct" privatization of health structures. But when health system reforms fall within the framework of sweeping privatization programmes for the economy at large, the impact of this overall process on what happens in the health section is more limited.

The models of state disengagement and privatization implemented in productive sectors cannot be automatically applied to social sectors. A uniform approach to changes of ownership in the health sector is inappropriate. There is no ideal combination of solutions to three strategically important issues: centralization/decentralization; self-management/state regulation; public/private medical institutions.

Privatization of the health sector, like other sectors, is not free from social ideologies, political considerations or electoral rhetoric. From time to time governments state their intentions to develop public structures and improve care quality but in certain quarters, there is no support for solutions envisaging privatizing part of the care system to remedy problems of the national health service. It is also deemed unconstitutional to have users of the medical system pay part of its costs. And it can also be true that to establish the general rules of competition and markets to a special sector like health care can potentially give rise to untenable disparities.

The disengagement of public finance institutions from the economy means introducing privatization within the health structures themselves. In fact, the logical move is as follows: cautious management reforms with the objective of achieving a sounder financial footing later followed by structural reorganization of the entire system. It can be considered that privatization is latent in some of the changes in status of public services, and that it will surface eventually in one form or another. Dysfunctions in some public health systems tend to accentuate the trend towards creating private care and funding structures, notwithstanding the political desire in some circles to continue to entrust social security management solely to the State.

Some features of the health sector in the Soviet Union

The health systems in the Russian Federation, Ukraine and Georgia were developed according to the Soviet model; they were extremely centralized and with a totalitarian approach to management, financing, material-technical provisions and overall control. For health care, the strategy, volume, means of implementation and budgets were determined centrally, with complete disregard for any economic incentives for institutional development. Despite the declared preventive orientation of Soviet health care, most of its efforts were in fact directed towards patient care. The number of bed/days spent in hospital was regarded as one of the indicators that the system was functioning successfully. This in turn led to more beds and more medical staff. Under these circumstances, it was not surprising that the Soviet Union far outstripped the

developed Western countries in the number of hospitals and beds available and this fact was often used in official propaganda as proof of great achievements in health care.

The system at that time regarded an individual as a passive user rather than as an active agent able to influence the organization and management of such matters. At the same time, the individual's right to health protection was to some extent violated since he did not have the right to choose freely which health institution to go to or which physician to consult.

The wage level in the Soviet Union was held down artificially by a factor of 5-7 compared with the West, and it was assumed that the difference was compensated by the free benefits paid out of public funds. The State's social policies were designed to: determine the economic development rate and build up public funds from various sources including profits of enterprises, institutions and organizations, and charity donations. Public funds were supplemented by private fees charged for medical services.

In addition, a significant burden of costs, including those for the maintenance and repair of medical institutions, was borne by enterprises which included such expenditures in their overall operating and production costs. When market reforms began in the economy, medical institutions found there was a severe shortfall in such funds.

This type of state role involves excessive oversight and results in a lack of self-development or of competition mechanisms. Also an individual's responsibility for his/her own material security and economic self-reliance is reduced to a minimum.

Society had been permeated with these ideas suggesting that the best way for the country to develop was to eliminate distinctions with regard to consumption of goods and services and have the State ensure social justice through legislative standards and provisions.

Some special features of the transition period

The Government began to introduce radical reforms in the administration and financing of activities previously fully funded out of public coffers. They made reforms not only in the public administration and civil service sectors, but also in social services.

At the outset, this transition towards a market economy took place in a context devoid of a social protection strategy. As a result, the role of the State as the guarantor of social protection for society at large was rapidly reduced to a minimum.

A number of hastily drafted legislative instruments concerning programmes and projects were designed first and foremost to close the social guarantees gap without taking actual economic capacity into account. Panicky attempts to carry out social programmes in the health sector were devoid of a sound economic and social foundation and simply added to the crisis without resolving the underlying problems.

Chaotic privatization projects were often too extreme or were railroaded through, bringing about a whole new set of social problems in their wake.

To date, social protection has not yet become an integral part of a comprehensive national socio-economic management process.

The factors that caused the social protection crisis include: weak points in legislative provisions and standards; lack of a social standard; undeveloped social partnership; social impact insufficiently assessed by decision-makers; social protection not properly employee-linked (priority target groups are the elderly, the handicapped and so on); a lack of consensus between the legislative and executive powers as to the form that social management should take and the priorities it should adopt.

Society has had to face the same set of problems: how to finance a highly inflationary social intervention sector in a period when economic growth is non-existent. In the Russian Federation output plummeted by a drastic 40 per cent.

In most of the former republics of the USSR, the authorities developed policies to reduce health expenditures. Overall, the measures advocated were all broadly similar notwithstanding the respective institutional peculiarities of each country.

The need for fundamentally reorganizing health systems has become evident in all the ex-socialist countries as radical changes were made in their political system and in their social and economic affairs.

Political declarations have dwelt at length on the great importance of choosing an appropriate direction and orientation for health system renewal and on the complexity of the reform process involved. For example, the President of Georgia said: "Health-care reform is a great ordeal for the country as a whole and for every last citizen. It is not a matter of just one agency."

The Russian Federation, Ukrainian and Georgian health-care systems as they now stand reflect both the positive and negative attributes of the Soviet system from which they emerged. On the positive side, access is universal and the system is extensive. On the negative side, the system is not sufficiently funded to support the comprehensive services it attempts to provide, and the resulting quality of care suffers. Moreover, universality of access is more theoretical than real and in any case has been seriously jeopardized with marked inequities arising particularly with regard to better-quality and highly-specialized services, between different regions and socio-economic groups.

The Russian Federation health-care system is for the most part publicly funded. Until 1992, the main sources of health finance were the federal budget and enterprises. In Ukraine and Georgia the situation was similar. In the Russian Federation in 1992, responsibility for health financing was decentralised to the *oblasts*. In 1993, a 3.6 per cent payroll tax was introduced for compulsory health insurance. Decentralization, the introduction of the payroll tax, and entry on the scene by private insurers and providers radically changed the pattern of health-care financing.

Giving the health-care system a new direction is part and parcel of the strategic management of the country's social and economic infrastructure and is based on the principles of building a democratic society. Therefore, there is a need for basic changes to be made in the organizing principles of the entire system and in the concept of how different services should function and interrelate. The public purpose of the system needs to be clearly defined together with the social and economic mechanisms to ensure the system runs smoothly. An appropriate organizational structure for the health-care system needs to be drawn up and a new system of state management established; furthermore, new forms of health assistance based on mutual cooperative solidarity need to be developed.

Social development in the transitional period in all these countries has seen old problems exacerbated and fresh ones emerge. The peculiarity of the post-Soviet model of transition to a market economy consists of a policy to reduce labour cost, especially in sectors related to workforce skills training. Social distinctions, or, to be more precise, social polarization, is on the increase. The gap between rich and poor is widening. The process of income polarization is viewed by the majority of people as unfair and only one in ten consider it justified.

According to monitoring studies by The All-Russia Centre for Public Opinion Research, 40 per cent of respondents opted for a continuation of reforms, but to be pursued with a different orientation, namely one ensuring social protection for the population. The economic crisis, the unpreparedness of managers to operate under changing conditions and serious problems in the development of medical insurance led to a significant deterioration in health-care services. The sector suffers from a chronic shortage of financial resources even to meet the population's minimal needs. The money the sector receives is not enough to buy medicines, equipment or supplies, or even to pay wages to medical personnel. In 1996, wage arrears in the health sector increased at a higher rate than in all other social sectors. The establishment of paid medical services was meant to make up the financial shortfall of medical institutions.

In 1994, the Ministry of Health requested 13.7 trillion roubles to finance its medical academic and research institutions as well as its medical and prevention institutions under federal authority. The Ministry of Finance allocated 2.7 trillion roubles. In 1996, the figures were 23.9 and 4.8 trillion roubles respectively, or some 20 per cent of the amount required.

At present, the amount spent on medical services provided to the population has sharply decreased, and forecasts show a further reduction. The GDP share of expenditure on social and cultural sectors is 1.5 to 2 times less than that in countries with socially-oriented economies.

In Georgia, the amount of funds allocated by the State for health care has been cut drastically over the past five to seven years; this made it practically impossible for the population to be offered even minimum health care. The country's scarce financial resources did not make it possible to attain the stated objective of "free medical care for all".

In 1995-96, the budgetary principles, forms and methods for health care took a very different turn in Georgia. Instead of central budget financing, federal and municipal programme financing was established.

In 1995, 12.8 million GEL and 6.9 million allocated from the state budget were channelled exceptionally into supporting the reform of the health-care system. In 1996, instead of the 33 million GEL earmarked in the state budget for the needs of the health system, expenditure was only 20 million GEL, two-thirds of the estimate. A study carried out by UNICEF in 1996 indicated that only one-fifth of medical care expenditure was being met by the State. The major portion was covered directly by the population. It should also be mentioned that priority was given to developing energy and transport and medical matters weighed rather lightly.

Clearly, as medical and social care were accorded secondary importance, the state budget deficit was reduced by using funds from budgets earmarked for those sectors. This meant the State was unable to improve the situation in spite of the planned health-care reforms.

In the Russian Federation, as a result of past and current health-care investment practices, facilities are now in a disastrous condition: capital assets are worn out to the extent of 70 per cent or more. The necessary proportion between the active and passive parts of capital assets has been distorted not only within the existing network, but in facilities under construction as well — in the Russian Federation as a whole and in various regions. The passive part of the capital asset structure predominates. There is a significant disparity in equipment availability even in institutions exercising a similar activity and offering a similar level of services.

A great number of health-care institutions are located in premises not adapted for the purpose and, moreover, in a dilapidated state. Many of them lack the necessary accommodation. Only one-fifth of rural out-patient clinics are located in purpose-built premises. For a number of years, this sector was characterized by prolonged periods of construction because of shortages in building materials and production plants. At present, the start-up of production plants is being held up by one factor and one factor mainly — lack of investment.

In Ukraine, the most complicated situation is found in the villages where the number of medical personnel has been greatly reduced. In 1995, in 27 regional hospitals and in 90 out-patient units there was no doctor, and 461 obstetrics and doctors' assistants' units did not have any medical personnel of average level, either nurses or doctors' assistants.

One of the main causes for the health system's crisis in Georgia is the imbalance between the gradual reduction in funding and existing facilities. One hundred and forty-three curative and preventive institutions (8 of them under agencies other than the Ministry of Health) are operating in Tbilissi alone, a number far in excess of the city's actual needs.

Under the transition to a market economy, the socialist distribution model and pay policy were eliminated, but they have not been replaced by distribution relationships characteristic of a socially-oriented market economy.

All these failings in the way health services worked and the fact that insufficient credits were allocated to the sector meant not only that the private sector had to spend more but also that a

parallel health-care market emerged. The development of a "shadow" medical service has a long history. In the first instance it was brought into being through shortages: before 1991-92, there was a shortage of imported medicines and patients were limited in their choice of a medical institution; currently there is a lack of consumers able to pay for a course of treatment.

Medical workers hence seek out every opportunity for making money on the side, including allowing patients to jump the queue for a hospital bed, treating patients under the counter against payment no questions asked and no records kept, while using public facilities and medicines, etc.

Of course, the "shadow" income of medical workers is not taxed. Many who founded their own businesses some time ago now prefer to return to the state (municipal) health-care system, since there they have an opportunity, often encouraged by management, to engage in private practice; the same service is paid for by an insurance company and the patient himself (directly to the doctor), so medical workers are lining their pockets.

In the early 1990s, an attempt was made to instil in the collective consciousness the theory of self-reliance and pragmatism. That was the end pursued by practically all reforms in the social sphere involving the population's more active participation in the financing of social spending.

State regulation of the social process in health-care services

Government health-care policies are designed to ensure that a balance is struck in the consumer market among the following:

- citizens' constitutional health-care guarantees and the resources available to the State to deliver effectively on those guarantees;
- the governing bodies, i.e. the Government, the Ministry of Health, health-care management bodies in the constituent regions of the Federation, the Federal Compulsory Medical Insurance Fund and regional funds;
- sources of financing for all health-care programmes, i.e. the budget, insurance contributions and the population's disposable income or savings;
- medical institutions under different types of ownership through a legislative division of their spheres of activity;
- insurance companies and medical institutions.

According to international experts, for effective investment in health, government policies must be based on strict observance of the following measures and concepts:

- (1) Creating an economic and ideological climate conducive to making people want to take care of their health independently. The implementation of this measure requires, first, raising the population's living standard but, above all, also helping the poorer sections of the population through increased investment in education for prevention of illness.
- (2) Determining at the state level how money earmarked for health-care financing should be allocated: A package of health-care programmes must be developed and responsibility for its implementation provided to the executive bodies at the respective level of government. State guarantees with regard to health-care services are to be financed from the budget and social insurance. The practice of subsidizing health-care services in excess of social guarantees must end. It is more advisable to encourage voluntary types of medical insurance.
- (3) Promoting, at the state level, the development of different types of medical help while managing competition among governmental, non-governmental and private institutions in financing and organizing health-care services.

In Ukraine, Chapter 49 of the Constitution states that each person has the right to health care, medical care and medical insurance. Health care is provided from state financing of corresponding socio-economic, medical, sanitary, allopathic and prophylactic programmes. The

State creates the conditions for medical services to be made effective and accessible to all citizens. In state and communal health institutions, medical care is provided free of charge. The existing network of such institutions cannot be reduced. States promote the establishment and expansion of medical institutions under all types of ownership.

Chapter 17 of the basic instruments of health-care legislation in Ukraine says that the State assists and promotes the activity of individual entrepreneurs in the sphere of health care; licences for entering into such activity is to be provided according to rules laid down in the legislation. According to Chapter 18, health care is financed from the state budget and from local budgets, medical insurance funds, charity funds and any other sources not prohibited by the legislation. Departmental and other health-care institutions are as a rule financed by payments from enterprises, institutions and organizations receiving services from them. In addition, the same chapter states that the State should provide for the establishment and financing of the medical insurance system. Citizens are to be insured from the state budget of the Ukraine, the finances of enterprises, institutions and organizations, and from the citizens' own contributions.

State control of insurance activity in Ukraine according to Section IV of the Law is carried out by the Committee for Supervising Insurance Activity (*Ukrstrakhnaglyad*) established pursuant to the Decree "Concerning Insurance" by Resolution No. 743 adopted by the Cabinet of Ministers of Ukraine on 17 September 1993.

Issues connected with diminishing government involvement

Downsizing state ownership is the basis and core for reorganizing the existing economic and social structure.

Diminishing state involvement raises a number of issues that include a broad set of social and economic problems. The most significant of these are: maintaining social justice in the new distribution of ownership; suitable remuneration for work; and ensuring access to the nation's non-material wealth. The proper way to set about reducing state involvement is to begin the multifaceted process of removing state monopolies or quasi-monopolies from various spheres of economic, political and social relationships. This process should not be confined to changes in types of ownership. It must cover distribution and labour relations, methods and forms of business relations, and allocate the circulation of the nation's products and resources to the free play of market forces.

The specificities of state regulation are determined by price liberalization, reorganization of the credit and finance system, budget deficits and external debt. The key issue that emerged was the need to reduce the scope of administrative control, which was overbearing and ineffectual under the Soviet regime; however, related efforts have only served to make management more ineffective and further reduced the scope of legal regulation. The main task over the next decade will be to review the State's function as an efficient regulator of social relations and as a driving force for economic growth.

State disengagement as a process and event has no specific time-limits and will continue as long as the State remains. The forms and intensity of this process, however, will undergo significant changes. Curtailment of state ownership in health care is a complex multi-faceted process which includes: separation of powers between insurance bodies and management bodies so as to make the financial and management system for health care more democratic and provide medical help under conditions regulated by law; formation of medical associations; development of medical insurance organizations, associations; and strengthening control over the health-care system's activities through voluntary public organizations, primarily, through consumer groups.

The first step in the process of state disengagement must be to grant medical institutions all the rights of a legal entity, including the right to choose what forms their institutions and businesses will take within the limits of the legislation in force; at the same time, joint or mixed

types of ownership must be developed together with a private health-care sector. It should be noted that this process, as a social and economic development, is not directly connected with changes in types of ownership and can also effectively come about without such changes, i.e. within the framework of state (municipal) ownership. The aim and rationale of a smaller state role is to create internal sources and stimuli for economic growth, ensuring dynamic and efficient growth in the sector as a whole including all its institutions and workers. Diminishing state ownership is a process whereby the power of the health-care management bodies is reduced, and genuine organizational and business autonomy for medical institutions is established.

In the course of implementing social protection models, it must be remembered that post-Soviet countries still lack civil society institutions that can defend the population's rights; and there is also an absence of clearly defined legislative procedures for concluding pay agreements to cover the country as a whole, or a sector, an enterprise or an organization.

The Russian Federation study concludes that at this stage of market reform, there is a need to maintain a top-down pyramid structure for managing the social protection process.

Social and medical insurance

Cutbacks in centralized financing of the health-care system prompted people to look for other sources of funding. Compulsory medical insurance seemed to be one of the most attractive solutions since it created the possibility of ensuring citizens' rights to medical services at a time when market relations were first being created.

Social insurance is a complex multi-level system. In countries with a socially oriented economy, it is based on a state social insurance system with three levels: the State, the employer and the citizen. The State mainly acts as legislator and monitor of compliance with existing legislation.

The radical restructuring of social and economic relations now under way has affected the functioning of the state social insurance system.

The crisis in Russia's economic development has brought into existence some new types of social insurance unheard of in Soviet Russia, where each person was guaranteed a job. The transition to market relations has led to mass unemployment and to the need to introduce compulsory unemployment insurance.

Government policies on compulsory medical insurance are implemented through mandatory medical insurance funds and primarily through the Federal Compulsory Medical Insurance Fund. The funds are state owned. Their functions are as follows: to enforce the Law concerning the Medical Insurance of Citizens in the Russian Federation; to ensure social justice; to protect citizens' rights in mandatory medical insurance; to participate in drawing up and implementing government financial policies in this field; to secure the financial stability of the compulsory medical insurance system; and to devise and implement measures designed to standardize health-care services across the regions of the Russian Federation.

After the introduction of the Law concerning the Medical Insurance of Citizens, health-care management bodies almost completely lost their function as "buyers" of medical services since it was transferred to the medical insurance bodies. The same is true of the function of distributing financial resources to cover the cost of medical services provided to the population under the mandatory medical insurance programme. Medical institutions now have to earn those financial resources. The monopoly held over controlling the quality of medical services provided was also weakened since health-care management bodies are entitled only to limited departmental supervision; some of the corresponding rights have been transferred to insurance organizations empowered to protect patients' rights in medical services.

It should be noted that, according to existing legislation, the "buyer" of medical services — an insurance organization — has the right to enter into contractual relationships with medical institutions under various types of ownership. So long as state and municipal ownership of

medical institutions continues, the financial resources of the mandatory insurance programmes will accrue to these institutions. But medical institutions of other types, coming under various enterprises and departments, are also seeking to take an active part in implementing compulsory insurance programmes. Medical institutions of mixed ownership receive preferential loans from regional funds to buy equipment, but service-provider contracts under compulsory insurance programmes are signed for only one year.

When a medical institution enters the medical insurance system, it immediately comes up against these realities of decentralized financing sources.

Two schemes are proposed to finance medical institutions implementing compulsory medical insurance programmes and programmes financed from state resources and the municipal health-care system:

- (1) in keeping with actual services provided (actual costs plus a standard profit per unit of medical services);
- (2) for services provided, but on the basis of common rates and average costs (per hospitalization, according to disease classification and unit of service).

Both options are fraught with undesirable economic consequences.

The first encourages medical institutions to increase the volume of medical help provided to those insured, with little regard to quality. The money earned by poorly-equipped institutions will be insufficient for expanding throughput and quality. This model will perpetuate the poverty of such institutions.

The second option suits only medical institutions with average resources in the given region and is preferable for “worse” institutions.

Increasing competition among insurance companies is the best way to create conditions for establishing satisfactory types of health-care services through voluntary medical insurance. This kind of insurance is a specialized industry in which insurance technologies and the provision of medical help are closely interwoven.

Today the medical insurance market in the Russian Federation is actively developing and insurance companies are setting up their infrastructures. They are doing so under very difficult conditions:

- the legislative insurance base is far from perfect, and many practical issues remain unregulated;
- the population has not been prepared either psychologically or economically. Psychologically the population is geared to free medical care. Economically under the present crisis conditions only a few citizens can afford to pay for medical services;
- the tax system does not encourage industrial enterprises to allocate money to conclude voluntary medical insurance contracts on behalf of their employees.

One of the features of the development of the voluntary medical insurance market is that insurance companies have to provide various other kinds of insurance: accident insurance, life insurance, property insurance, professional liability of doctors, etc., although medical insurance is leading. Because there is no tradition of such insurance, the activity cannot guarantee a base income sufficient to maintain the insurance company’s infrastructure. That is why voluntary medical insurance is often combined with endowment insurance (mixed life insurance).

In voluntary medical insurance, there is a tendency to over-insure, even though formerly such insurance did not exist.

Voluntary as well as compulsory medical insurance is one of the forms of cover for the population. Today it is an important way for providing the population with paid medical services. Through voluntary insurance, the proportion of medical expenses payable by a patient is greatly reduced because such insurance is based on a “solidarity” model.

When medical insurance was first introduced, there was a clear trend towards widening the business rights of medical institutions, i.e. decentralization of management. Many institutions independently assumed the status of legal persons without coordination from higher-level bodies and have bought medicines and medical equipment on a contractual basis. As the financial crisis in the health-care system deepened, signs of power consolidation in the hands of management bodies once again appeared.

In the Russian Federation, independent insurance cover for the population within the framework of compulsory medical insurance is still at an early stage of development. There is a tendency for the insurer's function to be concentrated in the hands of compulsory medical insurance funds. There are no public institutions offering voluntary social protection.

In Ukraine, after the adoption of the Decree by the Cabinet of Ministers "Concerning Insurance" the number of commercial insurance organizations increased considerably. In 1994, there were already 660 but, as a result of more stringent control over insurance companies' activities, in 1995 the figure dropped to 487; in 1996, it was 500 and at the beginning of 1997, 400. This happened because in 1995 the Committee for Supervising Insurance Activity (*Ukrstrakhnaglyad*) had suspended or restricted the business licences of a considerable number of insurance companies; 134 insurance companies lost their licences to do business. In 1996, 150 insurance licences were taken away because of violations of insurance legislation. The Law concerning Insurance adopted in March 1996 changed the requirements for insurance companies: the minimum statutory fund was increased to 100 thousand ECU and this weeded out a number of insurance companies in business at that time.

This notwithstanding, the income of commercial insurance organizations rose by leaps and bounds. While in 1993 it amounted to 8,1 mln. hrv., in 1994 it increased 16-fold and was 130,4 mln.hrv.; in 1995 it increased by a factor of 1.67 (218,5 mln.hrv.) Amounts paid out in compensation were growing even more rapidly however. While in 1993 compensation payments amounted to 2,8 mln.hrv., in 1994 they increased 23-fold to 64,1 mln.hrv., in 1995 by a further factor of 1,8 (116,5 mln.hrv), and in 1996 by 2,5 (290 mln.hrv).

As was noted in the 1995 Annual Report of the President of Ukraine on the country's internal and external policies, the development of insurance services in Ukraine in 1995 cannot be regarded as a breakthrough in the formation of a market infrastructure. Nevertheless, both entrepreneurs and the population need reliable and effective protection and the insurance of property, assets, life and health.

In the main, in 1995 insurance companies carried on their activities as "economic societies"; a majority of these (628) performed as closed joint-stock companies and some were created with the participation of foreign investors. The most widespread types of insurance services found in 1995 were property and compulsory insurance. At the same time, insurance companies offering life insurance went into voluntary liquidation. The insolvency of some insurance companies caused by the high level of inflation, the unstable situation and the high level of uncertainty on the insurance market resulted in a loss of confidence among the population for this kind of service.

Currently, the income of commercial insurance companies within the economy of the Ukraine is insignificant — about 1 per cent of GDP by comparison to 7 to 8 per cent of GDP on average in developed industrial countries. These companies do not cover long-term credits or government securities, nor securities of joint-stock companies, of stock and commodity exchanges or of commercial banks.

As concerns voluntary medical insurance, according to information in *Ukrstrakhnaglyad*, it is very difficult to single out this activity because all commercial insurance organizations with a licence to offer life insurance can issue contracts.

Only two types of medical insurance have been introduced by special decision of the Government: medical insurance for the railways of Ukraine and medical insurance for foreigners.

Medical insurance for the railways of Ukraine was introduced as an experiment on 1 January 1996 by Resolution No. 773 of the Cabinet of Ministers of Ukraine of 18 December 1995; it is intended for employees of the Ukrainian railways. The experiment was carried out with the participation of the main medical service of Ukrainian railways, the Central transport clinical association and the joint-stock insurance company Transmedstrakh-Ukraine.

Medical insurance for foreigners who are living temporarily in Ukraine was introduced by Resolution No. 79 of the Cabinet of Ministers of Ukraine of 28 January 1997, according to Chapter 10 of the Law of Ukraine "Concerning the status of foreigners". The Resolution covers the provision of medical services to foreigners either under medical insurance, or, in its absence, at the foreigner's expense. Rules are established for the provision of such services. The Ministry of Health has to be the founder of State joint-stock insurance companies for the provision of emergency medical help to foreigners.

In Georgia, as of 15 February 1996, the process of shifting health care to modern health insurance principles had begun. Putting medical care on a health insurance foundation is one of the milestones of the second stage of reorganizing the health system.

As a rule, individuals are not able to cover medical expenses because of the high cost of medical care. Therefore it is necessary gradually to introduce widely accessible forms of medical insurance through the country, based on mutuality and cooperatives, as a way of guaranteeing health care to the population. The aim is to compensate for medical care expenses by using funds accumulated in accordance with established rules. Besides guaranteeing the provision of medical care to insured individuals, health insurance makes it possible for people to take better preventive measures.

Both forms of health insurance — voluntary and compulsory — will be used in Georgia. Compulsory insurance covers all the citizens and will be carried out according to the state insurance programme providing medical care and medicines.

The basic principles for state compulsory health insurance are as follows:

- any citizen may have access to health insurance guaranteeing the range and amount of services approved by the basic programme;
- any employed person covers part of his/her own insurance expenses in accordance with established procedures;
- the employer pays a predetermined proportion of the individual's insurance expenses;
- certain social groups designated by law are provided with insurance by the State.

Voluntary health insurance schemes provide compensation for expenses (through mutuality) in excess of the limits of state programmes; these may be collective or individual.

To shift most health care on to a health insurance basis, the State Insurance Company has been established; looking to the future on the basis of compulsory health insurance, this should ensure that state obligations in the provision of health care can be fulfilled for the population at large. The company has already started to provide vulnerable population groups with medical care. In the framework of certain insurance programmes, policy-holders are reimbursed for additional medical costs as well as for medical expenses incurred in the basic package.

The State Insurance Company and its regional subdivisions were established during the second stage of reorganization along with their material and technical supplies, including a diagnostic medical centre and relevant medical rehabilitation facilities. All this will allow the company to provide most of the population with compulsory health insurance by the end of 1997, thus guaranteeing that treatment costs for diseases included in state programmes will be paid for by the accredited health institutions participating in such programmes.

According to the Law concerning Medical Insurance, passed by the Parliament of Georgia in April 1997, voluntary health insurance will be provided by private insurance companies. There are already several such companies (Aldagi, Orbi, Imedi) which have been able to involve certain population groups and cover their medical expenses. But in the vast majority of cases, these are

well-off people (approximately 10 per cent of total population). For the remaining 90 per cent, the development of mutuality/cooperative services alongside the State Medical Insurance Company is probably the best solution to their problem.

Legislative aspects

The Russian Federation

The depth of the economic crisis has affected the possibility of carrying out reforms and the reforms themselves.

Reorganizing the "social sphere" means, first, establishing a legislative base where law determines the direction of development, i.e. sets up the models of the future. These models envisage free consumer choice, availability and adequate quality of services, a rational institutional framework for providing the services and a rejection of the state welfare monopoly.

The Russian Federation needs to reconsider the social guarantees provided under legislation enacted in the USSR, many of which are incorporated in the Constitution of the Russian Federation.

Medical services are one of the socially significant services; the constituent documents must be brought into accord with health-care legislation.

To date, a package of fundamental instruments has been enacted to regulate the activities of commercial entities under market conditions. These are: the Civil Code, the Criminal Code, the Federal Law "Concerning Non-Profit Organizations", and the Law "Concerning Medical Insurance". The following draft laws are under consideration in the State Duma:

- "Concerning the Privatization of Medical Institutions", later renamed, "Concerning the Reorganization of Ownership Relations and Institutional and Legal Procedures in the Health-care System".
- "Concerning Private Medical Practice".
- "Concerning Medicines" (approved by the Duma on 8 December 1995, rejected by the Council of the Federation).
- "Concerning the State Health-care System (introduced before the State Duma on 17 March 1995).

In January 1997, parliamentary hearings were held on two drafts of the federal law "Concerning the Introduction of Amendments and Addenda to the Law of the Russian Federation Concerning Citizens' Medical Insurance in the Russian Federation". This last law lays down the basis for the manner in which health-care institutions will operate.

Representatives of consumer groups have actively participated in drafting laws on health protection.

The Law "Concerning Citizens' Medical Insurance in the Russian Federation" has three main objectives:

- first, to set up an independent institution that would protect the population's guaranteed rights relating to health-care services under an emerging market economy;
- second, radically change the system of financing health care; and
- third, to continue the process of curtailing the State's presence in the sector.

According to the Law "Concerning Medical Insurance ..." citizens should be granted free health-care services at a level not below that of the basic federal compulsory medical insurance programmes.

The Constitution (Article 41) also lays down guarantees for the population of the Russian Federation concerning the provision of free medical services by state and municipal medical institutions under compulsory medical insurance programmes. These include targeted

programmes and programmes for socially dangerous diseases. However these legislative guarantees have not yet been implemented.

Citizens have the right to choose the medical treatment and prevention institutions as well as the doctors working under the compulsory medical insurance system. The basic programme defines medical service guarantees and includes all kinds of medical help; it also specifies the conditions governing provision and which population groups may have preferential rights to medical services given limited public resources.

Constituent documents should be made subject to stringent requirements yet to be drawn up. For some years now, preparatory work has been going on for a law to govern the basic conditions of the workings of the state (municipal) health-care system.

Georgia

The concept of health-care reorganization is based on the need to protect the population's health and to ensure the continuing development of Georgian medicine. The approach encompasses the major strategic directions of health sector development. In order to overcome the severe crisis in the health system, it has become essential to radically reorganize the system and implement a new model.

According to the concept adopted, among the major directions of system reorganization are:

- establishing the legal basis for the new health system;
- making the transition to health insurance principles and practice;
- supporting the privatization process.

Reorganizing the health system would not be possible without a sound legal foundation. Decree No. 400 issued by the Head of State on 23 December 1994 later ratified by Parliament, sets out a first statement of health reform. The Georgian health sector is to change from a centrally managed system financed almost exclusively from government revenues to a decentralized system with a basic programme financed by a payroll tax plus selected specific earmarked taxes and municipal subsidies. The remaining curative services are to be financed through the private sector. There will be a clear separation between funding sources, financial management and provision of services. This should create a competitive environment with incentives for greater efficiency in service-provision. Hospitals and other providers have been given great latitude in staffing and administration. The role of the Ministry of Health is being cut to strategic planning, monitoring and policy adjustment, including licensing and accreditation, quality assurance and provider regulation. The management of health service delivery will be decentralized.

Preparatory measures for reorganization were supported by Resolution No. 392 of the Cabinet of Ministers of Georgia (30 July 1995).

The Law "Concerning the Privatization of Health Institutions in the Republic of Georgia" was adopted. According to this Law, institutions will become private through employee buy-outs (EBOs) and those not privatized will be auctioned off. The institutions are placed into three categories:

- institutions that will remain with the same curative profile over the forthcoming ten years and will carry out state directives;
- institutions that will maintain their health service profile for not less than a ten-year period;
- institutions to be privatized without restrictions.

Several standard-setting instruments have been drawn up and approved by the Ministry of Health:

- Regulations governing the Privatization of Health Institutions;
- Regulations governing the Privatization of State Health Institutions.

The Law concerning Medical Insurance was approved by Parliament in April 1997.

By Presidential Decree (30 March 1997) the conversion of the State Health Fund to the State Medical Insurance Company was practically completed. The State Health Fund, set up in 1995 using part of the consolidated state budget of Georgia, was abolished.

The above-mentioned Law concerning Medical Insurance (April 1997) provides the population with legislative guarantees. This Law clearly lays down the duties and responsibilities of employees, medical institutions, the State and employers. Responsibility is determined according to the law as well as reimbursement for the cost of respective medical assistance. In addition, a new form of mutual solidarity insurance has been established. The population's active participation in the insurance process is thought of as active membership in building a democratic society. The expression "free medical care" was abolished.

The compulsory health-care fee became the compulsory health insurance fee. It will go towards financing the mandatory insurance programmes. Medical and prophylactic programmes will be funded from the general budget and all other programmes will be contract based.

The Law authorizes two forms of insurance: compulsory and voluntary.

Ukraine

So as to ensure reform in the social security system, Verkhovna Rada of Ukraine on 21 December 1993 approved the "Social Security Scheme for the Population of Ukraine" and instructed the Cabinet of Ministers of Ukraine, together with the respective Committees of the Verkhovna Rada of Ukraine, to prepare draft legislative instruments provided for under the Scheme.

The Scheme was designed and adopted to change the system in force at the time which operated with funding from the State and covered activities so broad that people felt everything was free. This only led to increasing demands on the welfare budget.

Under the new Scheme, medical insurance ensures the right of working citizens and members of their families to skilled medical care, material maintenance in case of illness and in certain other instances.

It also provides that a medical insurance fund be created from insurance contributions paid by enterprises and citizens themselves as well as from bank credits, other creditors and resources.

Taking into account the economic crisis and the fact that market relations in Ukraine are now just taking shape, it is impossible to adopt and implement all legislative instruments and standards concerning social security at once. Hence the Scheme provides for a two-stage reform process:

- Stage one, until the economic crisis is over, will keep the prevailing social security system going but make it more focused and improve the assistance provided to low-income users. It will also prepare draft basic legislation on social insurance, improve the management of the social insurance fund and introduce private insurance on a commercial basis.
- In Stage two, when the economic situation has stabilized, legislative instruments will be adopted and implemented, and the necessary organizational and financial measures to enforce social insurance reform taken.

A law concerning medical insurance is to be drawn up and adopted. Currently, the draft of this law is being reviewed by the Verkhovna Rada of Ukraine.

The social security system of Ukraine is being reformed according to the Constitution and the aforementioned Scheme. Practical reform measures progress is provided in the Annual Reports of the President of Ukraine and in the programmes of activity of the Cabinet of Ministers of Ukraine.

Chapter 46 of the Constitution of Ukraine, which was adopted by the Verkhovna Rada on 28 June 1996, says that citizens have the right to social protection, including the right to maintenance in case of full, partial, or temporary loss of ability to work.

This right is guaranteed under the general mandatory state social insurance system funded from insurance contributions paid by citizens, institutions and organizations, as well as from budgetary and other social security resources.

On 26 June 1997, the Verkhovna Rada adopted the Law of Ukraine "Concerning mandatory social insurance contributions" according to which 4 per cent of the Payroll Fund will be transferred to the Social Insurance Fund. The Law provides that, as of 1 January 1998, compulsory social insurance payments will be transferred to a separate line of the state budget.

Mandatory medical insurance in Ukraine does not exist practically. According to the Social Security Scheme for the Population of Ukraine, the Government is preparing a draft Law "Concerning Medical Insurance" which will provide for the introduction of compulsory state medical insurance with equal parity contributions to be paid by workers and employers. The draft Law is to be submitted to the Verkhovna Rada for discussion in 1997.

The medical care system is regulated by basic instruments of health-care legislation adopted by the Verkhovna Rada in 1993. The basic instruments determine the main principles of health care, the rights and obligations of citizens in the health sphere and the main directions of health-care policy.

Chapter 17 states that the rules governing the organization of medical insurance for the population and the use of insurance contributions or premiums is determined by respective legislation. So far no such legislation has been adopted.

The legal basis for the development of non-state social insurance was first laid down in the Decree of the Cabinet of Ministers of Ukraine "Concerning Insurance" adopted on 10 May 1993, and later in the Law of Ukraine "Concerning Insurance" adopted by the Verkhovna Rada on 7 March 1996.

Both the Decree and the Law were designed to create an insurance services market and did not cover state social insurance. The Law gives definitions of the main terms relating to insurance activity: risks covered, sums insured, compensation payable and the base amount for which the insured is liable. The premium payable, insurance rates, insurance and re-insurance, insurance agents and insurance brokers, insurance agreements, securing solvency of insurance bodies are also specified.

Chapter 2 of the Law establishes insurers as legal persons, as joint-stock, full companies, partnerships or companies with additional responsibility. In some cases insurers are defined as state organizations.

According to Chapter 13, citizens and legal persons have the right to create mutual insurance companies in order to provide insurance cover for their property interests.

Chapter 6 of the Law lists the types of mandatory insurance and medical insurance is one of them.

Given the need to expand the insurance services market, in 1997 a number of legislative instruments were adopted. These were designed to provide social protection and concern medical insurance. Considerable attention was paid to how to attract more of the insurers' reserve funds into investment in the economy. In 1996, by comparison with 1993, the reserve funds of commercial insurance companies increased 75-fold and amounted to 69,1 mln. hrv.; their income increased 41-fold and amounted to 22,4 mln. hrb respectively.

Privatization in the health sector

The shift from communism to a market economy offers better incentives for efficient work by introducing enterprises to financial discipline and competition. Privatization is one way of

increasing competition and improving performance, and cutting excessive labour and material costs.

Excessive labour and material costs as well as the presence of potential investors provide a good rationale for privatization of the health sector.

The chronic shortage of financial resources prompts management bodies to seek a solution involving at least the partial privatization of medical institutions or a broader base of paid medical services. The development of paid medical services can fill the medical institutions' financial shortfall.

Ensuring fair access to medical services according to personal income and efficient use of investment is another convincing argument in favour of privatization.

The objectives of privatization in the health sector are:

- to eliminate the health-care monopoly;
- establish a regulated medical market and development of appropriate economic actors;
- support the development of an internal market;
- establish an economic system to function effectively on the external market; and
- promote private ownership of medical and pharmaceutical institutions.

The above are intended to enhance the efficiency of the sector as a whole and increase the quality of care.

Privatization in the health sector will bring higher pay for health-care employees, and link pay directly to qualifications. The status of health-care employees will also rise. Another major consequence of privatization will be considerable saving of resources now spent on shoring up unprofitable institutions.

As an equal partner in market relationships, medical institutions may find it hard to survive and provide their workforce with job security. The aim is to be competitive on the open market, provide high-quality medical help while at the same time making the best use of financial and material resources and labour. This can happen only if the correct legal and practical approach is used. As an independent business unit, individual medical institutions will face some difficult realities.

In the Russian Federation, the transition to market forces and the deepening crisis in the production sectors prompted enterprises to reject the idea of maintaining their own social infrastructure facilities. In 1994-95, 13 per cent of enterprises transferred their social or welfare facilities to municipal authorities. As yet there is no government decree to authorize the privatization of social facilities — these were often regarded as plant workshops and eventually privatized.

In Georgia, considerable progress has been made since the privatization process began in 1992, but there is still a long way to go. Voucher privatization has finished but the State still holds 76 per cent of shares issued in medium-sized and large enterprises.

The privatization process came under the guidance of the Ministry of State Property Management: 448 health institutions have been privatized including pharmacies, outpatient clinics-polyclinics and dental clinics.

The two-year privatization programme consisted of four stages.

The first stage, concerning pharmacies, stomatological polyclinics, and separate medical rehabilitation centres was completed on 31 December 1995.

The second stage, concerning clinical-diagnostic institutions, medical rehabilitation units, and separate dispensaries ran from 1 January 1996 to 30 June 1996.

The third stage of privatization concerned dispensaries and polyclinics and was carried out from 1 January 1996 to 30 June 1996.

The last stage covered patient clinics and lasted from 7 January 1996 to 31 December 1996.

The step-by-step approach to implementation ensures that the interests of the population and employees are taken into account, especially in the privatization of major institutions. The terms of the programme apply to all state health institutions accredited as medical service providers holding the appropriate licence. After privatization, the institution maintains the licence but is obliged to submit a fresh application for accreditation.

The privatization of health institutions takes the following forms: direct sale, competitive bids, auctions and privatization with right of redemption.

According to the recommendations of the International Monetary Fund, the revenues received as a result of privatization with the exception of the expenses necessary to carry out the privatization process will be transferred to the account of the State Medical Insurance Company and used to strengthen health programmes.

The list of state medical institutions subject to privatization is approved and includes institutions divided into three groups:

- Group A: institutions subject to privatization with the requirement that they continue in operation according to state directives or basic programmes and maintain the profile for no less than ten years;
- Group B: institutions subject to privatization with the obligation of maintaining the profile of health institutions for a term of no less than ten years;
- Group C: institutions subject to privatization with no terms or conditions attached.

In the first stage of privatization, 109 institutions in Group A, 213 in Group B and 127 in Group C were privatized.

By comparison, between 1992 and 1996 in Ukraine only 126 health-care units were privatized. The Ministry of Health issued 8,226 licences which gave the right to engage in private practice to 4,927 physical persons and 3,299 legal persons, but there are no statistics on private medical practice.

In the Russian Federation, some people felt that the privatization process should be applied solely to medical institutions that traditionally provided paid services. Theoretically, the development of paid medical services will mean wider consumer choice for different forms of medical help. But the population is obliged to pay for medical services, and in many cases such expenses are not recorded as health-care expenditure. Also, most of the population lack the means to pay for medical services.

In 1996, the volume of paid medical services amounted to 3.8 trillion roubles, or 2.7 per cent of all paid services (in 1995 — 2.6 per cent). The highest rates have been recorded in Moscow, for example, an the initial check by a dentist costs on average 36,800 roubles; in Gorno-Altai 959 roubles, i.e. 38 times less.

High Moscow prices for paid medical services are caused by several factors: first, Moscow has some highly professional medical centres where the most qualified medical specialists tend to congregate. Second, there is a high demand for paid medical treatment. Third, a great number of private medical institutions are located in Moscow, borne out by the fact that the private sector accounts for more than 40 per cent of all licences to provide medical services.

In recent years, the growth rate of small enterprises in the health-care sector has not fallen as was the case in other paid services sectors. The number of small enterprises grew by 2 per cent in 1994 and 14 per cent in 1995.

As a rule, medical specialists engage in private entrepreneurship as a secondary job. Being employees at state and municipal institutions, they are in a position to win over clients who applied for free medical help.

Until recently, paid medical services were of an occasional, diagnostic type, but in recent years private hospitals have also appeared.

Paid medical services can be provided in three ways:

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- under voluntary, mainly collective, medical insurance contracts;
 - under direct contracts signed by enterprises with medical institutions covering the enterprise's workforce;
 - under individual contracts between citizens and medical institutions.

Medical services are only one of several socially significant services. In the absence of a general strategy for managing the development process of all social services, a pronounced market bias towards medical institutions can lead to adverse consequences and to an unjustified diversification of help pattern. There is a high price to be paid for making mistakes in the health-care privatization process. In some instances moves toward privatization have been rejected; for example, in St. Petersburg where the privatization of municipal pharmacies has been halted.

In the Soviet Union of the mid-1980s, territorial medical associations were established that had a monopoly on medical service provision in a given region, particularly in rural areas. At present, many obstacles are placed in the way of granting the status of legal persons to medical institutions which had had such status before joining the territorial associations. The separation of some units from medical institutions must be prevented, if such separation would impair the technological integrity of medical help provision. There have already been attempts to separate surgical departments and diagnostic services and convert them into independent legal entities.