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FINAL REPORT

Annex 2 - Part 1

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EXECUTIVE SUMMARY

Amidst the blizzard of policy papers descending on Moscow, "Healthy Russia 2000" is unique. Reform of the health-care system in Russia is already underway, but with wide regional and sectoral differences in the progress made to date. Accordingly, any policy discussions and recommendations can only be taken as part of an evolving, ongoing process. No policy "prescriptions," no snapshot of public opinion and no econometric model are fixed references, but only way stations along the process of health-care reform. In effect, therefore, this is a working paper on which work has already begun, and which will necessarily continue while the paper's recommendations for future implementation are studied and launched.

In Section I, "Healthy Russia 2000" sets forth a vision of the future of Russian health care. Today, there exists the possibility of achieving (a) meaningful universal access to (b) enhanced, efficiently-provided, cost-effective health care through (c) increased consumer choice and competition among health-care providers leading to (d) better health and greater satisfaction for the people of Russia. Emphasis will be placed on all four components of health care: prevention, early detection of disease, treatment and rehabilitation. Some aspects of health care (e.g., pharmaceutical manufacturing, distribution and retailing) can be privatized entirely. Other aspects, such as hospitals and polyclinics, will have more diverse possibilities, including continued government ownership, transfer to local-government control, management by not-for-profit organizations or outright privatization.

Section II describes Russia's current state of health, which, in short, is not good. Compared to OECD countries, Russians have shorter life expectancies; higher illness and mortality rates among working age persons; higher infant mortality rates; and a general weakening of the population's immune system because of environmental pollution, alcohol abuse and allergies among youth. The birth rate has decreased, the general mortality rate has increased, and the population is aging. The young, women and the elderly are particularly vulnerable, and men have the lowest life expectancy in any European country.

In Section III, "Healthy Russia 2000" examines the current state of the health-care system, especially available resources, in light of the health problems previously described. Significantly, the causes of many of Russia's health-care problems are manifestations of the overall difficulty of the transition away from prior structures and practices. Institutional resources, such as hospital facilities, are in relative over-supply but their physical condition is poor. The numbers of physicians and nurses are high, but their talents are not well utilized (often being spent on menial, non-medical tasks), and their pay and morale are low. Shortages of medical equipment are serious, aggravated by shortages of funding to purchase new, higher-quality equipment. The supply of pharmaceuticals is well below necessary levels. Plants are obsolete, production expertise for many drugs is lacking, and product ranges are outdated. The distribution of pharmaceuticals is one of the most serious problems in the entire health-care system, and will need significant restructuring, as will retailing. Health care has been historically underfunded, and national budget constraints have only grown worse. The Compulsory Medical Insurance law ("CMI") is in the early stages of implementation, and private payments are still a small percentage of the total expenditures for health care. As a result, real expenditures for health care are falling. Thus, the present system suffers from insufficient public funding, and yet also fails to attract private resources in sufficient qualities to meet aggregate needs. Brief analyses of the Dutch, German, British, Swedish and American health-care systems are provided to allow readers and decision makers to compare the existing Russian system to possible alternatives.

Section IV describes the results of the first systematic effort in Russia at consumer and provider polling on health care. Opinion is widely divided on the adequacy of existing health care and the need for reform. Younger, better-educated people tend to be more dissatisfied with the present system, and more ready to pay for increased care, compared to older, less-well-educated Russians who tend to prefer the system as it is. Wide regional variations also exist. Providers seem quite aware of the possibility of insurance, but consumers are far less informed. Despite existing public-information campaigns intended to improve lifestyles and thus health, very little real change in behavior has occurred. Nonetheless most Russians are optimistic about the future of health care, and there is a large minority supportive of major reforms in the system.

Section V describes a new approach to Russian health care, stressing that increased efficiency and competition can allocate scarce resources more effectively, especially since total resources available for health care are not likely to grow to any extent in the near future. Preventive medicine and increased consumer choice should be stressed. The pharmaceutical manufacturing, distribution and retailing industry should be privatized, and new local-government, not-for-profit and for-profit hospitals and polyclinics should be established. The CMI system must be made to work better, and sources of private financing need to be thoroughly explored.

Section VI proposes concrete steps to implement the new approach, some of which are already underway. Additional steps can be undertaken immediately, and some others will have to await the outcome of the general debate on health care expected in the near future. Substantial new laws and regulations will be needed to shape the new private and local-government institutions that will be created, and prevent the creation of new monopolies. Financing remains difficult, but steps must be taken to preserve meaningful access to universal care. Increasing workforce training and maintaining the quality of care are critical. Major work is needed to reshape the pharmaceutical industry, especially distribution. More effective public-education campaigns, for both consumers and providers, are essential to the reform program's success. Finally, a Presidential Commission will create stronger public support for this major undertaking.

SECTION I

A VISION OF THE FUTURE OF RUSSIAN HEALTH CARE

The people of Russia desire -- and deserve -- a health-care system equal in quality to that of the other industrialized democracies, and consistent with the World Health Organization's goal of "Health for All by the Year 2000." For too long, the Russian people have been prevented from attaining the goal of a healthy Russia because of policies designed to achieve ideological objectives which the people are now rejecting. Scarce resources were diverted, wasted and misallocated, and the health of the Russian people was impaired. Government bureaucrats made all of the key decisions about health-care, rather than the citizens themselves. As a result, health-care for Russians is in jeopardy. Today, however, there is a new opportunity to turn the system around that must be seized.

Today, there exists the possibility of achieving:

- meaningful universal access to
- enhanced, efficiently-provided, cost-effective health care through
- increased consumer choice and competition among health-care providers, leading to
- better health and greater satisfaction for the people of Russia.

This possibility, which will be accomplished through a major reorganization of the health-care sector, represents a critical priority for the government of Russia. Without doubt, it will be a monumental undertaking, and will have to take political realities into account, but it should nonetheless be embraced by all of those concerned about a healthy Russia.

Universal access to health-care, although theoretically available in the country, has too often been inadequately realized because of favoritism, inequality in the distribution of personnel and resources, and inefficiency. Chronic underfunding -- because health was actually a low budget priority in the Soviet Union -- resulted in poor performance. "Universal access" became yet another political slogan masking the harsh reality of scarcity and rationing. A "Healthy Russia 2000" will make universal access a fact rather than simply rhetoric by empowering the Russian people to make their own decisions about health-care, and by providing adequate incentives to providers and other

suppliers in the health sector. There is already a generous supply of trained medical manpower which can and should be put to better and more productive uses.

Enhanced, efficiently-provided, cost-effective health-care is central to the new system. Allowing increased control and decision making by individual consumers, providers, and payor organizations over virtually all aspects of health-care, from hospitals to pharmaceutical distribution and retailing, will increase efficiency and cost-effectiveness almost immediately, and it will enhance the actual provision of health-care shortly thereafter as new and improved procedures, medications and facilities come into general use. In the four broad areas of prevention, early detection of disease, treatment, and rehabilitation, "Healthy Russia 2000" will ensure better services, drugs and medical products for the Russian people.

Increased consumer choice and competition among providers is fundamental to restructuring Russia's health-care system. By providing the people with options, thereby increasing competition among the providers, together with increasing the incentives for providers to be more responsive, "Healthy Russia 2000," through a strong partnership between government and the private sector, will make available the benefits of market forces. Campaigns to increase public awareness and understanding of the new system will help ensure that adequate information is available both to health-care consumers and providers. High-quality goods and services will be available more consistently with the people's actual requirements.

Better health and consumer satisfaction must be the ultimate goal of any reform in Russian health-care. Opening and reorganizing the financial, legal and all other aspects of the health-care system will be done with a clear vision that it is the people themselves who must benefit from the extensive changes that will be required, especially for the elderly, women, children, and other target groups. "Healthy Russia 2000" is not a plan for the privileged and the powerful, but rather one intended to benefit Russians throughout all regions of the country and throughout all segments of society.

In the field of **preventive medicine,** Russia lags far behind most industrial democracies. Yet prevention is now attracting more and more attention in those countries, both because of its overall contribution to individual health, and because of the important impact it has on holding health costs down. It is far more efficient and cost-effective to prevent medical problems than to cure them after they begin. Thus, for example, the Russian environment and dietary habits must be improved, workplaces must be made safer, and the excess consumption of alcohol and tobacco, and the use of illicit narcotics, must be curtailed for a "Healthy Russia 2000." These steps alone would substantially increase both the personal health and productivity of many members of the Russian work force and their families.

The **early detection of illness** can likewise have a powerful impact on individual well-being and cost containment. Curing illness before it becomes clinically advanced is better for the patients and their families, reduces the adverse impact on the economy from lost productivity, and is less costly overall. This is especially true for children, where early and periodic screening and vaccinations produce tremendous human and economic benefits. Because Russian procedures in the past have been oriented toward hospital treatment, much will need to change. Here, competition among physicians, polyclinics and other providers should be quite important in moving toward an emphasis on the early detection of illness. Public health interventions and policy will also be important.

Treatment obviously remains central to achieving the goal of a "Healthy Russia 2000." Making hospitals more efficient means that scarce resources can be used to bring better care to a larger proportion of the population. Competition, through vesting hospital ownership in private companies, non-governmental organizations, or municipalities; privatizing polyclinics; and permitting the private manufacture, distribution and retailing of pharmaceuticals and medical equipment can be an important factor in bringing about the needed changes. Increased efficiency and cost-effectiveness in the provision of care can help reduce costs and benefit both providers and consumers.

Rehabilitation remains an important part of health-care, but it also must change. New opportunities will emerge as a result of the expected de-emphasis of in-hospital treatment, as the discipline of new

payment mechanisms reduces the length of hospital stays, once again enhancing the welfare of the patients and their families, while simultaneously reducing the costs of health-care.

No one doubts that the process of achieving a "Healthy Russia 2000" will be difficult. The state of the overall national economy will be an important factor. There are substantial differences among Russia's regions in the provision and quality of health-care, in the availability of resources (financial, technological, personnel and institutional), and in methods of financing. Substantial underfunding exists throughout the country, especially as government budgets fall in a difficult macroeconomic environment. New insurance plans are only partially operational, and their efficacy and long-term viability still too early to predict.

New legal and regulatory structures must be conceived and implemented successfully, involving new modes of ownership, commercial transactions and taxation. Standards for the production quality of medical goods and provision of services must be sustained and improved. Providers of foreign economic cooperation must believe that serious reform is possible and worth the commitment of substantial external resources. Potential foreign investors must also be convinced of the viability of trade and investment. Public confidence and awareness about the benefits and importance of the restructuring must be stimulated and sustained. Health-care providers, manufacturers and distributors must become enthusiastic advocates for change. There must be a strong coalition of support in the Duma.

"Healthy Russia 2000" fully understands the gravity of the obstacles which must be overcome, and it does not underestimate the difficulty of the mission it faces. Nonetheless, "Healthy Russia 2000" does not shrink from the tasks before it simply because they are difficult. To do so would be to break faith with the people of Russia, who are themselves bravely struggling to create a democratic, free and prosperous society across the board. There is evidence that the high and rising death rates in the former Soviet Union were a major cause of regime instability, and thus a contributing factor to the collapse of the Communist dictatorship. But high death rates can also cause instability in Russia's newly-emerging democracy, threatening a return to the discredited old ways. This result

must be avoided, and it counsels against being overly cautious or pessimistic about the prospects for success.

Moreover, the process of restructuring has already begun, although in a fragmentary, erratic and spontaneous manner. In many places, privately-owned pharmacies are selling to consumers, and some physicians have already been providing fee-for-service medicine to their patients for decades. Polyclinics and hospitals have asked for advice and assistance on how to privatize. Pilot projects are underway in a variety of medical fields and Russian regions, to show the benefits that will flow from reform. Substantial authority and responsibility have already devolved from the central government to regional and local authorities. Financing mechanisms and the provision of health insurance (public and private) have begun to shift. These efforts are proceeding even in the face of massive economic, legal and logistical difficulties, and their ultimate success will largely depend on supportive changes throughout the health-care system.

"Healthy Russia 2000" recognizes that not all aspects of the health-care industry can be treated in exactly the same way. Some aspects (such as the manufacture, distribution and retailing of pharmaceuticals) should be fully privatized on an accelerated basis. Other aspects (such as polyclinics) will be somewhat more complicated. Still others (such as entire hospitals) will be amenable to a range of alternatives, from for-profit ownership, to tax-exempt non-governmental organization, to municipal or regional ownership. The fact remains, however, that the process of reform must begin, and must begin now, capitalizing on Russia's unique experiences and present knowledge, and the expected advances of the next decade.

"Healthy Russia 2000" describes the current state of health in Russia (Section II), and explains the current health-care system (Section III). It then examines the results of extensive survey research to discuss the perceptions of Russian consumers and professionals, and what these opinions can tell us about the present situation and future prospects (Section IV). Finally, "Healthy Russia 2000" describes the new approach to health-care (Section V), and how it will be implemented (Section VI). Extensive Annexes provide supporting information and resource materials.

SECTION II

RUSSIA'S CURRENT STATE OF HEALTH

The Russian Federation is a multi-national state with a total area of more than 17 million square kilometers, and a population of approximately 148,600,000. Seventy-eight percent live in the European areas, 22% in the Asian areas, and 73.3% live in urban regions. Health in Russia, as compared to the developed countries, is characterized by:

- shorter life expectancy;
- higher illness and mortality rates among working-age persons (especially among men) from cardiovascular and oncologic diseases, accidents, intoxication, injury, murders and suicide;
- higher infant mortality rate;
- high rates of illness and mortality from illnesses of the respiratory and digestive systems and infectious diseases among infants and young children; and
- weakening of the immune system of the population because of environmental pollution; alcohol abuse, and allergies among youth.

In short, the health of Russia population is in a dismal state, and is continuing to deteriorate.

Different types and levels of public health-care vary from territory to territory. These differences are most clearly evident in the following regions:

- The rayons with traditionally compact industrial development, established social infrastructure and complicated ecological situations: North-Western, Central and the Urals economic rayons.

- The rayons with developed industry, but in which local centers alternate with vast, thinly populated regions, with difficult ecological situations and unfavorable natural conditions: Northern, West-Siberian, East-Siberian and Far East economic rayons.

- Agricultural/industrial territories with unfavorable ecological situations in rural areas (such as inefficient utilization of pesticides and fertilizers, or poor organization of cattle breeding farms): Volga-Vyatsky, Central Black-Earth and Povolzhsky economic rayons.

- Based on a comprehensive analysis of health indicators, the hazardous regions are: Tuva, Khabarovsk region, Sakhalin oblast, Kemerovo oblast, Irkutsk oblast, Krasnoyarsk region, Komi Republic, Magadan oblast, Tomsk oblast, and Novgorod oblast.

In addition, there are regional differences in the levels and rates of illness and mortality. Thus, in 1992 the mortality rate in Russia was 12.2 per 1,000 people. This index varied from 9.6 in the Far East to 14.3 in the Central Black-Earth region, while among administrative territories it varied from 5.7 in Chukotsky national okrug to 16.6 in Pskov Oblast. In 1993, for the first time in post-war history, more people died in Russia than were born, and the population declined by 800,000.

In 1993, the infant mortality rate was 19.1 per 1,000 newborns, compared to 7.4 in Western countries. The index fluctuated from 15.6 in the Northwestern rayon to 20.8 in the East Siberian rayon. On the oblast level, the fluctuations are even greater, from 14.1 in the Karachaevo-Cherkessk Republic to 32.3 in Tuva. Regional differences are also evident in the rates of illness and mortality from infectious, parasitic, and oncologic diseases, and diseases of the digestive system.

Since 1992, the birth rate has decreased from 10.7 to 9.2 per 1,000 people, the general mortality rate has increased from 12.2 to 14.6 per 1,000; at the same time 1.4 times as many people died as the result of trauma and intoxication as in 1992. The major causes of death are endogenous diseases (blood circulation diseases, malignant neoplasms and some others). For example, in the Murmansk oblast in 1993 the birth rate fell from 10.9 in 1990 to 7.2, the general mortality rate grew from 7.5 in 1992 to 9.9, and the incidence of narcotic-related disorders increased by 25.4%. A decrease in the birth rate, and an increase in mortality rate for young working-age people will result in an increased share of the elderly in the total population. As a result, the number of chronic care patients will grow.

As for preventive care, the highest priority must be given to the prevention of non-infectious diseases, since 96 out of every 100 deaths result from non-infectious diseases. High hospitalization rates and long hospital stays (at least 24 days for therapy and 13.5 for surgery) suggest there is a particularly low level of preventive and primary care, although hospitalization rates appear to be declining (from 25.5 per 100 people in 1985 to 21.8 in 1993). The high mortality rate from infectious diseases, in relation to rates in developed countries, results, in large measure, from the very same unfavorable life conditions which also cause non-infectious diseases:

- Unhealthy life style (poor nutrition, in particular: shortages of proteins, vitamins, vegetable fat and nutritional fibers; smoking, alcohol abuse, and insufficient physical exercise);
- Unfavorable ecological factors, especially in industrially developed areas;
- Unfavorable sanitary and hygienic conditions at manufacturing enterprises;
- Psycho-social stress, caused by the socio-economic difficulties of this transitional period; and
- Deterioration in the quality of medical services while the health-care system is being restructured.

A. MAJOR DISEASES

Infectious Diseases. Compared to developed countries, the rate of acute intestinal infections, such as salmonella and viral hepatitis, is higher, particularly in regions with unfavorable social, economic, sanitary and ecological conditions such as Dagestan, Chechnya, Ingushetia, Siberia, Tuva, and Buryatia. Tuva is one of the leaders in prevalence of type "A" and "B" hepatitis as well as intestinal infections. The rate of diphtheria and measles continues to rise in all of the administrative areas, particularly in overpopulated areas such as Moscow and St. Petersburg. Diphtheria cases alone grew 110 percent in 1992. Children's infections such as pertussis, measles and poliomyelitis persist.

The average rate of tuberculosis in Russia, now considered a social disease, is 34.2 per 100,000, and varies from region to region: from 23.1 in the Northern rayon to 83.7 in Tuva. The highest rates of

tuberculosis are in the Povolzhsky, North-Caucasian and West-Siberian rayons. Over one-third of tuberculosis patients are diagnosed with advanced cases, indicating the importance of prevention.

The rate of natural-focal infections is growing. The major zoogenetic infection is hemorrhagic fever with renal syndrome which has spread to 45 administrative territories in Russia. The highest concentrations are found in Bashkortostan, Udmurtia, and the Mari-El Republic. Natural foci of tularemia continue to exist in Russia (mainly in the Central, Central Black-Earth and Volgo-Vyatsky rayons). In urban centers such as St. Petersburg, pockets of leptospirosis are developing. The natural foci of Russian tick-borne encephalitis are the forest zones of 38 administrative territories, with 85-90 percent of cases now registered in the Urals, East and West Siberia and the Far East.

Parasitic pathology (opisthorchiasis, diphyllobothriasis, etc.) is the most prevalent disease among the populations of the North, Far East and Northern Caucasus areas and, to a significant extent, it defines public health in these areas. The growth rate of syphilis, gonorrhea and other venereal diseases, as well as pediculosis and scabies also serve as indicators of a troubled society.

Oncologic Diseases. The growth rate of illness from cancers in Russia is closely connected both with the general aging of the population and the worsening ecological situation. Early identification is crucial. Among patients diagnosed with original incidences of oncologic disease, those whose cancer is in the first or second stage account for 35.8%. In Russia, "pre-invasive" cancer accounts for 0.4 out of every 100 patients with original incidences of malignancies.

In 1992, the rate was 271.6 cancer cases per 100,000 people. Among men, the primary types are: lung cancer (28.6% of cases), carcinoma of the stomach (15.8%), carcinoma of the skin (7.6%), and hemoblastosis (4.5%). Among women the primary types are: breast cancer (17.4%), carcinoma of the stomach (12.4%), carcinoma of the skin (12.3%) and carcinoma of uterine cervix (5.8%). The rate of disease for men is 1.8 times higher than that for women. The highest rate of cancer is found in the Sakhalin Oblast; among men, in the oblasts of Magadan, Novgorod and Murmansk; among women, in the oblasts of Kaliningrad and Chelyabinsk, and in Tuva and Adygeya. The highest rate

of lung cancer as well as the highest growth rate is in the European areas of Russia such as the Leningradskaya, Nizhijorodskaya and Chelyabinskaya industrial oblasts.

Cardiovascular Diseases. Cardiovascular diseases became the leading cause of death in 1992, at 646.0 per 100,000 people. Ischemic heart disease and cerebrovascular diseases are the largest contributors to mortality, with high blood pressure a leading risk factor. In addition, hyperpietic disease is a significant factor in mortality rates. Approximately 30% of deaths from cardiovascular diseases are among working age persons (ages 20- 59), and roughly 15 percent of school children suffer from high arterial pressure. Mass control over arterial hypertension, timely identification of those who suffer from high arterial pressure, identifying "dislipoproteinemias" and reducing the risk factors will diminish the incidence of cardiovascular pathology.

Mental Health. Psychiatric diseases, including narcological disorder, have long been widespread. The rate of original incidence of psychic disorder cases (excluding alcoholic psychosis, chronic alcoholism, drug abuse and toxomania) was 106.6 per 100,000 in 1992. The rate of original incidence of alcoholic psychosis, chronic alcoholism, drug abuse and toxomania was 107.6 per 100,000. Alcoholism is responsible for 95.9 percent of all cases of mental illness. The rate of registered cases of mental illness in rural areas is 2 to 2.5 times higher than the rate in urban areas. The rayons with the worst mental health situations are the Central, Volgo-Vyatsky, and Central Black-Earth rayons, as well as the West-Siberian and East-Siberian regions. In the last several years, the rate of anxiety, depression and obsessive-compulsive disorders has continued to rise.

Respiratory Diseases. Acute forms of respiratory diseases predominate, one of the major causes of personal disability and economic losses. The primary chronic respiratory diseases are chronic bronchitis, emphysema, pharyngitis, tonsillitis and adenoidal diseases, pneumonia, bronchial asthma and allergic rhinitis.

Diseases of the Digestive System. The rate of diseases of the digestive system is growing. Gastric and duodenal ulcers are the most serious of these diseases.

Endocrinopathy. Diabetes mellitus is a principle concern, characterized by high rates of disability and mortality. With so many problems connected with providing proper nutritional foods and drug shortages, the condition of patients has worsened. Endocrinopathy prevention should focus on identifying individuals with defective glucose tolerance who constitute a diabetes melitis risk group, and screening of newborns for congenital hypothyroidism. Endemic and non-endemic diseases of the thyroid gland are also a problem. More than half of Russia is characterized by endemic goiter (in particular Bashkiria, Tatarstan, and the Urals). The most unfavorable territories are those affected by the accident at Chernobyl particularly the western rayons of the Bryansk oblast.

B. MAJOR PATHOLOGIES OF PARTICULAR PATIENT GROUPS

Children. The most important index of children's health and the well-being of society is the infant mortality rate. In 1992, it was 18.0 per 1,000 newborns, the highest mortality rate among economically developed countries. Some territories have stable, low infant mortality rates, and other have stable high rates. Territories with low rates are located in the European part of Russia, and the territories with high rates are mainly vast territories of Siberia and the Far East. The rates vary greatly from 15.6 in the North-Western area to 20.0 in the North-Caucasian and 20.8 in East-Siberian areas. In Chechnya and Ingushetia the rate increases to 30.7. The leading cause of infant mortality in virtually all industrial areas is prenatal pathologies (asphyxia, birth defects, and prematurity), accounting for 44.5% of all infant deaths. The second leading cause of infant mortality is congenital developmental defects (21.4 %), and the rate of diseases from exogenetic, avoidable causes such as respiratory, infectious and parasitogenic diseases, remains rather high (25.8%).

The rate of illness among infants is high: 20.3 % of newborns had congenital pathologies or became ill soon after birth. Infants of low weight (less than 2500 g) are 7 % of all newborns, and premature deliveries are 3.9% of the total. When they leave the maternity hospital for home, only 48.3% of newborns are generally healthy, 43.9% are included in the risk group for development of chronic diseases, and 7.8% have serious prenatal pathologies. In the first year of life, 40 to 60% of children are diagnosed with rickets, hypotrophy, or diathesis, and 10% are diagnosed with anemia.

Respiratory disease is the most prevalent illness among children, followed by illnesses of the sense organs and nervous system. The number of children with some abnormalities in physical development, such as obesity at early ages and weight deficiency during school years, is growing. Fifteen to 20% of children under seven, and 30% of schoolchildren have some form of chronic disease. Among children finishing school, 45% have chronic diseases, and are restricted in their choice of profession for health-related reasons. Children's disability is 3.28 per 1,000 children, and 25% of serious disorders are mental.

Women. Reproductive disorders are a very serious problem; 10 to 12 % of young girls and teenage girls and 40 to 60 % of women of reproductive age have some sort of gynecological disease; 10 to 15% of married women are sterile. Wide-spread abortions have a very negative influence on women's health. Complications following abortions are one of the main causes of maternal death. Arterial hypertension, hypercholesteremia and obesity are widespread. In 1993, normal pregnancy and delivery occurred in only 20% of cases. More than one third of pregnant women had extragenital pathology, more than 60% had obstetrical pathologies, and 21.6% of pregnant women suffered from anemia. Pregnancy among women with pre-existing chronic diseases is often complicated by toxemia, spontaneous abortion, and anomalous labor activity. In 1992, the rate of maternal mortality was 50.8 per 100,000 live births.

Men. Russia has the lowest life expectancy for men of all European countries, 11.7 years less than that for women. The decrease in men's life expectancy over the past seven years is directly connected with accidents, intoxication and trauma. For working age men (ages 20 - 44) the rates of death from these causes is very high. During the past ten years, the death rate among men from accidents and traumas has varied with the rate of alcohol abuse, which has been growing. Among Moscow teenagers nearly 80 percent drink alcohol. In 1993, 2,500,000 men were in treatment for alcoholism and alcohol psychosis. The rate of alcohol abuse in Russia rises from north to south.

The Elderly. More than 60% of elderly people have some chronic disease; 40% of men and 60% of women ages 60-69 suffer from arterial hypertension. Every fourth man and every fifth woman

is overweight, while 10% of men and 25% of women have hypercholesterolemia. Among people 60 years and older, 30% suffer from some chronic disease with disorders of organism functions. Ischemia, chronic non-specific lungs diseases and pneumonia are of greatest concern.

SECTION III

RUSSIA'S CURRENT HEALTH-CARE SYSTEM

A. OVERVIEW

Reform of the Russian health-care system actually began in the mid 1980's, but was very erratic in nature, not changing the system overall. Such a limited approach was insufficient to solve the numerous problems the health-care system faced with the introduction and development of market-oriented policies. In health-care, the situation is still very difficult, especially because of high rates of both general and infant mortality, the decrease in the birth rate, and the decrease in average life expectancy to 67.9 years.

The deterioration of the economy resulted in the total number of physicians of all specialties falling from 47.3 to 45.0 per 10,000 people. Drug supplies worsened as well. Production decreased by 13%, imported purchases decreased by 12%, and purchases of domestic drugs decreased by 18%. Approximately 60 -70% of drug requirements appear to be satisfied, but information is incomplete. Prices for certain drugs are currently increasing significantly faster than inflation. These developments are characteristic of most regions of Russia.

The cause of the current condition of health-care lie, for the most part, outside of the health sector, one of many manifestations of the overall crisis in Russia. These problems, no matter how grave, are only symptoms of a troubled society. The future of Russian health care depends in large part upon overcoming negative trends in the standard of living of the population, health status, and finally the success of market reforms and the extent of their social orientation.

The increased share of health-care services requiring payment does not, as yet, correspond to the population's low income level. The income of approximately 30% of the population is lower than the official minimum subsistence level, and the income of 15 million people is half this level.

The difficult situation in Russian health-care is a product of the weakness and instability of the Russian financial system. In 1993, the budget deficit was 11 trillion roubles and increased more than 11 times (while the inflation rate increased 10 times). Several independent experts estimate the actual budget deficit at 22-24 trillion roubles (15% of GNP). The result is the abrupt reduction of budget financing of the whole social sphere, including health care. In fact, health-care financing is based upon what funds remain after all other programs have been funded. In 1993, only 1.4% (1992, 1.7%) of total Federal budgetary expenditures were allocated for health-care development, and the health-care sector actually received only 67% of that amount. In comparison, in 1985 USSR budgetary expenditures for health-care were 4.6%, and, in 1960, 6.6%.

Nonetheless, health-care financing is not as desperate as it may seem at first. In Kursk oblast, for example, in 1993 health-care policy continued to operate as a unified state system. Working under conditions of economic instability, this unification was possible because of the professionalism of the medical staff and the development of new market-oriented methods of work in medical institutions. Moreover, oblast budget expenditures for health-care in 1988 constituted 6.9% of total expenditures, 7.8% in 1991, 12.5% in 1992 and 17.1% in 1993. Medical institutions have also been authorized to provide services for payment, constituting 0.9% of total overall financing.

The introduction of market policies inevitably leads to decentralization of health-care management, and many management functions have been transferred to local bodies. Health-care financing will remain mostly regional because the lion's share of tax revenue remains there. Compulsory Medical Insurance ("CMI") also means that most funds are administered at the regional level, perhaps reinforcing previously existing regional variations in health-care levels. The federal CMI fund will mitigate differences, but is unlikely to eliminate them. Decentralization of health-care financing shifted major decision-making responsibility to the regions. This is a positive phenomenon, because it both increases responsibility for the local population's health and gives more freedom and independence on practical decisions such as those involving financing of local health-care.

Changes in the Russian health-care system are gaining strength, and the implementation of market reforms is proceeding. However, these processes (ranging from free medical care to wholly private medical practice), as a rule, are evolving non-systematically and without coordination. On one hand, positive results are evident as the health-care system adjusts to market requirements: the number of beds decreases, the overall effectiveness of use of hospital beds increases, the medical staff is reorganized on the local level, and the volume and range of polyclinic and outpatient hospitals services increases. On the other hand, the financial status of medical institutions is unstable, the share of paid medical services is increasing despite the inability of the majority of the population to pay for such services, and the hospital mortality rate has increased from 1.1% 1.4%

The system of obligatory medical insurance can play an important role to lessen the effects of difficult financial conditions. Presently, several medical insurance programs have started to function (obligatory medical insurance funds, medical insurance companies), though the implementation of these programs is slow and irregular. In spite of all the shortcomings and contradictions, however, the system of medical insurance deserves multilateral support, because it represents the first attempt to coordinate economic development with health-care needs. At the same time, the lack of an organized system of medical insurance results in a lack of reliable data on the distribution of finances within the system.

B. CURRENT RESOURCES

The deterioration in health conditions set out earlier is directly related to the lack of adequate resources in health-care. This section will describe the current resource situation in Russia and how it worsened, in four categories: (a) institutional resources; (b) human resources; (c) technological resources; and (d) financial resources.

Institutional Resources. The number of hospitals and polyclinics in Russia, and their capacity, has slightly declined over the last three years. Currently there are 130 hospital beds per 10,000 people compared to 135 in 1991, compared to 90 hospital beds in the West. The number of polyclinics

decreased from 20,900 to 20,600, but is still higher than the number of primary care facilities per thousand in most Western countries. (see Table 2).* Hospitals and clinics are owned by the government. There are also clinics and hospitals owned by the industrial enterprises, estimated to represent around 10% of the total. Private hospitals and polyclinics are rare. Private ownership is more common among outpatient specialists, such as private gynecological and dental clinics.

The physical condition of Russian health-care provider institutions is poor. There is little recent data on the condition of the facilities, but according to a survey conducted in 1989, 85% of hospitals require some repair. Many lack basic sanitary and hygiene conditions, and 45% of hospitals do not have any on-the-premises baths or showers. (see Tables 3 and 4). The problem, therefore, is not the supply of hospital beds and primary care, but the unsatisfactory quality of existing, obsolete facilities. Lay-outs are inefficient (such as no connection between buildings and departments within one hospital, narrow lobbies, and no elevators) and wards are overcrowded (6-12 people per ward, some mixed sex wards). Serious violations of sanitary and hygiene standards exist even in the best institutions (e.g., asbestos materials in hospital cafeterias and buildings, lack of toilets, washbasins, and waste disposal). Heating and ventilation systems are extremely uneven, with some rooms and corridors overheated and some very cold and drafty.

Newer facilities are better in some respects, particularly in site layout. However, construction of new facilities has been declining during the 1990's and essentially stopped in 1993 due to a decrease in government funding for capital projects (see Table 5).

Human Resources. This section addresses the human resources of direct health-care providers, e.g., physicians, nurses and paramedicals employed in hospitals and clinics. The number of physicians per 10,000 people varies from 77.8 in Moscow to 23.8 in the Checheno-Ingushskaya autonomous region, with 45 being the average for Russian (see Table 6). This figure exceeds the number of doctors in the West, which ranges from 14 in the U.K. to 30 in Germany. The number of doctors

* Tables, Exhibits and Figures may be found in Annex III.

in Russia has remained stable over the last three years. The number of "paramedicals" (including both nurses and other trained medical assistants) per 10,000 people varies from 150.8 in Murmanskaya oblast to 87.7 in Kaluzhskaya oblast, with 113.6 being the national average.

The relative "oversupply" of physicians means that doctors perform many tasks done in the West by nurses, such as X-rays, basic diagnostic tests and monitoring. This in turn reduces the nurse's role; many nurses perform tasks carried out in the West by orderlies, such as bed pan collection. The combination of low pay, long hours, and unskilled work assigned to nurses has led to a shortage especially in large cities. Trained nurses are leaving the profession, and hospitals typically cannot fill vacancies for nursing/paramedical staff. Morale is low, with both doctors and nurses frustrated and angry about the inadequacy of facilities and equipment, and the shortage of medicines and basic health-care supplies. Hospitals deal with these problems in a variety of ways: for example, some use their own pharmacies to produce basic supplies (e.g., saline solution).

The average physician's salary was around 110 thousand Rb ($66 per month) in January, 1994, 20% lower than the national average wage of 134 thousand Rb. The average nurse's salary was 80-85 thousand Rb ($50),or 60%-70% lower than the national average (see Table 7). The decline in physicians' and nurses' pay has led to a large increase in private payments, estimated in 1991 to be 20%-25% of total health-care expenditures. These payments are now significantly higher; specialist physicians earn ten times their official salary by treating patients privately. Private prices are routinely quoted for a variety of conditions at better facilities. Payment is also required for shortening waiting list times, additional medicines, treatments, and use of the newest technology. Even mundane requests to nurse and paramedical staff can require payment. Although the use of unofficial payments has long existed in the Russian health-care system, the present scale and extent in the health-care sector is a recent phenomenon.

Training of physicians and nurses is conducted in 80 medical institutes and several hundred nursing schools. There are 217,000 students in M.D. equivalent programs, requiring six years of study. The Soviet policy was to have a medical institute in every oblast, and, therefore, each large city has at

least one. The problems in medical education are similar to those in health-care generally: lack of adequate facilities, lack of equipment, and underpayment of faculty and support staff.

Technological Resources. This section describes the supply and availability of medical equipment, pharmaceuticals, and medical supplies in hospitals and polyclinics. The level of equipment and technology varies by the type of institution. Some federal specialized centers are relatively better equipped and have a higher level of technology, such as Cardiocenter and Oncocenter in Moscow. There are also certain hospitals and clinics belonging to industrial enterprises and ministries that were previously better equipped than regular Ministry of Health ("MOH") institutions. However, this may not still be the case, as enterprises cut back social expenditures. For example, the Ministry of Transportation's hospital and polyclinics have not purchased any equipment for the last two years.

The last survey of medical equipment, conducted in 1989, showed a severe shortage of even the most basic equipment, such as X-ray machines and automatic blood counters. Equipment is inadequate in all therapeutic categories, with a particularly severe lack of cardiac, vascular, orthopaedic, and renal equipment. Even better-equipped Moscow hospitals lack essential equipment. For example, Hospital Number 5, with 200 beds, uses manual blood counting and only has two X-ray machines.

Equipment shortages are so serious that they preclude even basic treatment, let alone modern care. For example, lack of diagnostic equipment leads to a very low rate of early disease diagnosis. Thus, most patients receive either no care, or more-expensive, less-efficient care in later stages.

The equipment procurement system is practically unchanged from the time of planned economy, and is based on direct budget financing. Heads of hospitals and clinics must apply for equipment to local health authorities. Delays in replacing outdated and broken equipment can take several years. The allocations are based on capacity, not on number of patients served. Health authorities have a high element of discretion, causing abuse and bureaucratic favoritism.

Lack of budget funding and inefficiencies in procurement procedures are a constant source of frustration to Russian medical personnel. Doctors routinely set aside some of their own private payments for equipment purchases. Although this is still a small percentage, it clearly signals that the official system fails to provide even basic equipment.

The supply of pharmaceuticals covers only 60-70% of demand. In some cases, under-supply reaches 80-90%. Average consumption of pharmaceuticals in $10 per capita in manufacturers's prices compared to $125-250 per capita in the West. Part of these shortages is due to the collapse of supplies from the former USSR republics and Eastern European countries, and this supply vacuum has not been filled by increasing sales of Western and Asian drugs. Moreover, most doctors are unfamiliar with Western-manufactured medicines, and have very limited access to educational publications. Inefficiencies of the distribution system contribute to drug shortages and high prices. Russia does not have an adequate manufacturing base to produce essential drugs in sufficient quantities. In 1992, there were 91 enterprises engaged in manufacturing of pharmaceutical substances, ready forms and medical equipment (Table 8). Production failed to cover even 40 percent of demand for six out of eight major drug categories (Table 9).

There are several reasons why pharmaceutical manufacturing is so inadequate. First, plants are obsolete. Virtually no new plant (aside from the Akrihin joint venture with Bristol Myers Squibb) has been built in over 15 years, and some actually date from the turn of the century. Not only are these plants inefficient, they also pose significant risks to customers who buy their inconsistent and often impure products and to surrounding populations, which are threatened by their existing and continuing environmental problems.

Second, Russian producers lack expertise in the production of many pharmaceuticals. Under the previous system, Soviet producers focused mainly on the production of substances while the production of finished forms was left to the East Europeans. Even today, imports from Eastern Europe account for nearly 40 percent of the market. Thirty percent of essential drugs were never produced in Russia.

Third, product ranges are outdated and excessively complex. In a given therapeutic category, leading Russian products are often one or more generations behind leading Western products. Western companies are often unwilling to provide newer licenses, both for economic and for quality control reasons. Some Russian companies produce as many as 150-200 products, creating complexity which increases costs as well as contamination risk.

Finally, organizational structures are inefficient. The ratio of indirect to direct production employees is far too high. At the same time, marketing and sales departments are embryonic or ineffective. Distribution networks tend to be poorly developed, given the breakdown of the old central system.

The current Russian pharmaceutical wholesale system is inefficient, and will need significant restructuring. The wholesale margin level (10 to 25%), and its ratio to the retail margin level, are strong indicators of the efficiency problem. Wholesale activities are characterized by low inventories, high administrative costs, and low service levels. The current structure consists of approximately 100 wholesalers, with about 130 warehouses. Table 10 compares the Russian pharmaceutical wholesaling sector with various Western and Eastern European countries.

The average size in terms of sales is smaller than in Western Europe, reflecting lower drug prices in Russia and, importantly, the absence of related product lines like cosmetics, periodicals, housewares, and other products. However, the number of pharmacies served per warehouse is very high, surpassed only by Germany and the U.K., which have highly-efficient, fully-automated warehouses with sophisticated information systems. In order to improve service to pharmacies (e.g., frequent deliveries, wide product line) the number of warehouses must be increased, particularly taking into account the likely increase in the number of pharmacies.

The wholesalers are monopolies in their regions, although new private wholesalers have entered the market in Moscow, St. Petersburg and a few other major cities. In other countries, relatively few national wholesalers compete intensively with each other across the country. National wholesalers also provide an efficient service to pharmaceutical manufacturing companies, which do not have to

deal with over 100 regional wholesalers, as in Russia today. The differences in structure are shown in Table 11.

Pharmacies in Russia, though not very numerous (16,000, or 1 for 9,200 inhabitants), have limited sales (typically $150 to $170,000 annual drug sales per pharmacy, versus $500,000 to $600,000 in the West). Given the comparatively low penetration of pharmacies relative to population, the number is likely to double in the next several years. (See Table 12)

Financing. This section examines the sources of funds for health-care and their main uses, as well as the major mechanisms of fund collection and allocation. Care should be taken with all of the data, because much of it is inexact. The overall crisis in institutional, human, and technical resources is compounded because the health-care finance system is not supplying sufficient revenue to run the current system, let alone to improve it. Historically, health-care in Russia has been underfunded, only 2-3% of GDP compared to the OECD average of 8%. Even accounting for lower wage costs, total health spending per capita has been insufficient. Recently, Russia's health-care budget actually declined in real terms, dramatically.

The health-care financing system is plagued by a number of problems:

- historical underfunding;
- capacity-based funding, causing hospitals to keep high occupancy rates to acquire more beds;
- financing of medical employment rather than care;
- lack of basic financial management skills among health-care administrators;
- lack of information technology; and
- high inflation and underdeveloped capital markets hindering the development of insurance funds.

Health-care financing has undergone three significant changes over the last few years: (a) significant reduction in real spending; (b) introduction of compulsory medical insurance ("CMI"); and (c) decentralization of funding. The current system of financing is a mixed budget-insurance system,

where compulsory insurance funds are supposed to cover direct expenses (e.g., labor, medicines, food in hospitals) for treatment of the employed population. Federal and regional budgets cover all other expenses. Government budgets currently fund more than half of health-care expenditures, but the percentage financed by CMI is increasing.

After increasing for several years at an annual rate of 6-8%, budget spending on health-care collapsed in 1992. The nominal governmental expenditures increased from 37 billion Rb in 1991 to 341 Rb in 1992, but retail prices increased 26 times, and producers' prices increased 34 times. Real expenditures thus decreased by 95% (Table 13, Figure 1). This collapse was somewhat mitigated by subsidies to enterprises and ministries that financed their medical facilities. The total amount of these subsidies is unknown, but it is unlikely they exceed 10% of overall expenditures.

Hospitals were by far the largest recipients of health funds, or 57% in 1991; in the West, hospitals receive 44% of total health-care funds (Table 14). Only 3% of funds is allocated to public health, suggesting Russian health-care is oriented towards curative, inpatient care. The actual total budget expenditures were 3600 billion Rb.

In 1992, 80% of the health budget was administered by the regions, with a relatively high share for salaries and social insurance of up to 60-63. (Table 15). The projected 1993 budget totalled 1,407.9 billion Rb:

- Salaries - 58%
- Food - 9%
- Pharmaceuticals - 8%
- Medical supplies - 1%
- Repair and maintenance, utilities, transportation, etc.- 15%
- Contribution to CMI - 9%

In 1993, 1.1 trillion Rb was accumulated by CMI funds, which amounting to only 16.4% of the planned CMI proceeds of 6.7 trillion Rb. In 1994, CMI funds hope to collect 25-26 trillion Rb. By MOH estimates, the health-care system needs at least 34 trillion Rb, and the Ministry suggests that employers' tax should be increased to 6.7%. There is very limited information available on a regional level as to the amount of funds accumulated and how these funds were distributed, but it is estimated that territorial CMI funds collected only about 35% - 40% of potential proceeds in 1993. By 1994, yields were approaching 60%. There are wide regional variations in collection rates, For example, in Archangelsk, the collection rate is only about 5%, whereas in Krasnoyarsk it is close to 100%.

In Moscow, the CMI fund collected 75% of potential proceeds in 1993, 92 billion Rb and distributed them as follows:

- 54 billion Rb to create the required reserve;
- 19 billion Rb to raise the salaries of medical personnel in Moscow;
- 18 billion Rb to replenish pharmacies' working capital after wholesale price increases; and
- 1 billion Rb for the Fund's expenses.

Significant amounts of money were allocated by old discretionary methods.

Size and allocation of health budgets by regional authorities is illustrated by interviews in the Tver and Perm regions (see Exhibits VI and VII in Annex III). The share of salaries has been reduced to 26%, and more funds were spent on equipment, repair and maintenance, and utilities (up to 40%) compared to the planned federal split. Drastic reduction in real health-care financing resulted in freezing practically all capital expenditures. The involvement of regional health authorities in financial management differs. For example, Oblzdrav (Health Department of Regional Administration) of Novosibirsk region pursues a hands-on approach, and is involved in all purchasing and distribution of most supplies. In Tver, however, hospital authorities make most decisions independently within the allocated budget.

Personal expenditures once accounted for 8-12% of total health-related expenditures, mostly to purchase pharmaceuticals and optics, with only 16% going to medical fees (Tables 16 and 17). These numbers do not reflect, however, direct cash payments from patients to doctors and nurses, which some estimate in 1991 were at least eight times reported personal expenditures. "Supplementary cash payments" are now a major source of income for many doctors.

The Russian health-care system lacks sufficient resources to provide adequate care, especially financial and technological resources and quality hospital facilities. Human resources are less strained, but there is an urgent need to improve training, and provide better working conditions and higher salaries. Financing is in transition to a western-type system. The CMI mechanism does not collect nearly as much revenue as it should, the success rate varies by region, and needs to be modified. Budget financing still dominates, with 60-70% of funds being sourced and allocated via traditional channels. This government-funding shortfall must to be augmented from private sources.

Overall, the reimbursement scheme is not rewarding efficiency and preventive care. Patients do not have a choice of provider, and providers are reimbursed for the number of operations performed. Hospital inefficiencies, particularly unnecessary long stays and chronic "full capacity," consume cash desperately needed for improvements in treatment and facilities. Private financing does not provide funds for capital expenditure, since doctors have little incentive to invest money in a state-owned facility. Therefore, the present system suffers from insufficient public funding, yet also fails to attract private resources.

C. COMPARISONS WITH OTHER COUNTRIES

This section outlines the principles and funding mechanisms of five OECD health-care systems. It describes: (i) the Dutch and German systems of "sick Funds"; (ii) the British and Swedish systems, characterized by direct government funding through taxation; (iii) the United States system with its mix of private and public funding.

THE NETHERLANDS

Philosophy of the Health Care System. Health-care services originated largely from private initiatives, often charitable. The hospital system was historically organized confessionally (Catholic or Protestant) or politically (socialist or liberal). Despite mergers and joint ventures between different institutions, the majority are still charitable and not-for-profit, and are owned and operated by private, locally-controlled, independent boards.

Philanthropy has been gradually replaced by public finance and government regulation. Key moves in this direction were the introduction of the Exceptional Medical Expenses Act of 1967 ("AWBZ") and the Health Insurance Act. The AWBZ initially covered long-term or high-cost care. By 1992, its role had expanded to cover 45% of all health-care expenditures. It is likely to expand further, representing eventually a basic insurance scheme for the entire population. The Health Insurance Act, now finances basic medical and hospital care for about 60% of the population.

A key characteristic of the Dutch system is that the whole population is covered by health-care insurance; 66% of the population is covered by the Sick Funds (publicly funded insurance), while 33% are covered by private insurance. Today, government has overall responsibility for policy, and the actual system is characterized by a public/private mix of finance. Contributions to the costs of health care are based on the ability to pay, and access to essential services is based upon a definition of need. Most doctors work as private practitioners. High expenditure on health care has led to attempts to control cost, but the result remains unclear.

Financing. Health care spending of 8.1% of GDP is high by European standards. (See Table 18). Historically, total spending on health care was governed by patient demand (which is unlimited) and particular incentives for providers to treat patients. Today, spending is increasingly determined by political negotiations seeking to balance budgets against patient and provider satisfaction. Regulatory pressure exists to limit doctors' incomes, and constrain hospital capital expenditure.

Increase in AWBZ funding is due to the impact of reforms which seek to channel finance through one central fund. The government currently funds approximately 11% of health care expenditure, through grants to the AWBZ and by providing cover for civil servants (6% of the population). (See Table 19)

Finance for the Dutch health care system is raised as follows: (1) 45%: AWBZ covers the entire population through compulsory social insurance for the costs of serious illness or long-term disability; its revenue derives from income-related tax payments by employees and central government grants; (2) 24%: Health Insurance Act (only for those earning less than $23,550 in 1990) covers the cost of GP services, short-term hospital care and dental care. Revenue derives from income-related tax payments made by employees and employers and nominal flat-rate premiums; (3) private insurance funds paid from individual insurance premiums: these cover the self-employed and those higher earners not covered by the Health Insurance Act, about 32% of the population; (4) payments made by individuals, which can be in the form of co-payments; and (5) civil servants, 6% of the population.

Health Care Outcomes. The standard of care in the Netherlands is considered to be good. Patients have ready access to a comprehensive range of services and wide choice among providers. Surveys indicate a high level of public satisfaction with the health-care system, second only to Canada. Health measures indicate favorable conditions. Life expectancy for both sexes is among the highest in OECD countries, and there are very low infant mortality and crude morality rates. (See Table 20)

System Reform. The Dutch system is currently undergoing significant reform. The three main features are: (1) one basic benefits package for all citizens with consumers choosing the insurer and details of the insurance policy they desire; (2) greater incentives for efficiency in the delivery of care as insurers negotiate contracts directly with providers; and (3) a shift from government regulation to greater reliance on managed competition. Both Sick Funds and private insurers compete for enrollees, and receive risk-adjusted capitation payments from the central fund.

The financing mechanism will be changed to a simpler structure, with 85% of financing coming from a central fund into which income related taxes are paid, the remainder to be paid directly to the chosen insurer in the form of flat rate premiums (the premium size will be a function of the chosen policy and insurer, but not of individual risk).

GERMANY

Philosophy of the Health Care System. The German system is embedded in the so-called "social market economy" which forms the framework for German social and economic policy making: self-governance, social partnership and social solidarity. Self governance means that purchasers and providers of health care should operate as self-managing private organizations with as little interference from government as possible. Social partnership means that both employees and employers should share the burden of financing health care. Social solidarity means the economically stronger members of society should support the weaker members to ensure equality.

The financing of the German health care system is characterized by self-governing statutory insurance funds. Over this century, the proportion of people thus insured has risen from around 20% to 90%. Entitlements are generous by international standards and free at the point of delivery, fueled by the population's entitlement-benefit mentality, and reimbursement methods largely based on a fee-for-service regime. There are no waiting lists for medical treatment.

The health-care system covers everything except long-term or permanent care, and is based on compulsory insurance. This highly-decentralized scheme uses Sick Funds organized on a local, company or national basis, which reimburse health-care providers for a broad range of services (excluding long-term residential care). Sick Funds follow the principle of payment in kind, and they have an obligation to deliver services or products, but not to reimburse patients. There are a number of different types of funds: some cover geographic areas and companies; others cover different professional groups. Much of the population is automatically insured upon self-registration or registration by their employers, although the choice of insurance funds is restricted. For employees,

it is usually the Sick Fund near their workplace. Firms with more than 1,000 employees may open a company-based fund, if this does not endanger the local fund.

In the early 1970's, health care expenditure increased rapidly as a percentage of GDP. With the economic recession of the late 1970's, the Government passed several reform acts. The Health Care Act of 1989 went further, increasing co-payments for hospital stays and some drugs, and introducing random reviews of doctors and the cancellation of contracts with uneconomic hospitals. The 1993 Health Care Structural Reform Act introduces a mixture of radical organizational reforms and stringent cost-containment measures in many areas. For example, patient co-payments have increased for a variety of services; doctors must budget for drugs and their services; and the current full-operating-cost reimbursement for hospitals is replaced with a fee-per-case. As a result, the government has projected total 1993 savings of DM10.1 billion, over 3% of health-care expenditures.

Financing. In 1990, Germany spent 8.1% of GDP on all health care, which is above the OECD average. Only 14% of health-care funding comes from the government. The major financing is through self-governing statutory Sick Funds (46%), and also by payments made by employers (17%), pension funds (7%), and accident insurance (3%), which are mainly channelled through the Sick Funds. Other sources of funding are direct patient payment (7%) and private health insurance (6%).

The funds are largely financed through a proportional payroll tax levied on earned incomes, with both employer and employee contributing equally. In 1993, the average German's Sick Fund insurance premium was about 14% of wages. Sick Funds also act as the first recipient of the individual's pension and unemployment contributions. Other sources of Sick Funds' revenues include transfers by pension funds, local unemployment offices and welfare organizations. People on higher incomes can switch to private health-care insurance. Approximately 90% of the population are insured with one of the compulsory insurance funds; 8% are covered by private

insurance, and the remaining 2% are mainly civil servants for whom the Government administers health care. Less than 0.5% of the population has no coverage at all.

Health Care Outcomes. The German system works well in many respects. The range of benefits to which Germans are entitled is considerable. There are extensive facilities, and access is easy and relatively uniform in West Germany. There are few waiting lists, and the quality of care is considered to be high by international standards. Upon reunification, it was decided to bring the Eastern system into line with the Federal Republic. By 1991, a complete network of local Sick Funds was operating in Eastern Germany.

UNITED KINGDOM

Philosophy of Health Care System. The National Health Service ("NHS") was established in 1948 and remained essentially unchanged for forty years, allowing considerable time for a series of powerful political and cultural beliefs to form. These include wide public support for the concept of a full range of health care freely available to all; a strong lobby for equal quality care for all; and a political aversion to "profiting from ill health." By the late 1980's, a number of problems had become apparent: massive inefficiency, long waiting lists, a highly bureaucratic system, and an inability to cope with greater demand. In 1990, major health-care reform was enacted to use health-care resources more efficiently. The current reforms shift decision making to local districts and providers; separate the purchase and provision of care; and reorganize the structure of primary, acute and community care.

Financing. The proportion of GDP spent by the government on health care in 1992 was 5.7% compared to 6.1% for 1990. Health-care expenditure per capita at purchasing power parity is one of the lowest in the EU, and as a percentage of GDP is the lowest of all EU countries.

There is extensive national public involvement in both financing and providing care. Around 94% of all health-care spending is funded by the central government. NHS accounts for nearly 90% of

U.K. expenditures, and 95% of this is financed through general taxation and national insurance. As a result, the Treasury has enormous power to influence total spending; even under the new reforms, there is full Treasury control over supposedly financially independent NHS trust hospitals.

Publicly owned hospitals predominate, with a majority of doctors, nurses and other health service workers salaried employees for, or contractors of, NHS. Six percent of health care is funded privately, either through supplementary insurance or direct patient payments. The proportion of the population covered by supplementary insurance has increased over the last decade, reaching around 12% in 1991. However, coverage is typically limited, and is used to supplement elective procedures for which there are often long waiting times within NHS. Those who buy private insurance receive no exceptions or refunds from national insurance contributions.

Individuals contribute through taxation or national insurance contributions, regardless of actual levels of use of the system. Individual contributions mainly relate to the ability to pay. NHS is funded by general taxation (79%), national insurance contributions (15%), charges (4%) and the sale of land (2%). Income tax is deducted at source for the majority of employees. Tax levels vary broadly by income, with higher earners paying a higher proportion of salary in taxes. National insurance contributions are tantamount to a tax on earned income. Employees' national insurance contributions amount to 9% of their income, starting at £2,808 a year, and up to a maximum ceiling of £21,060. Employers' contributions vary between 4.6 and 10.4 percent, depending on employee income level.

Health Care Outcomes. The life expectancy of U.K. males and females is very similar to the OECD average. The infant mortality of 7.9 per 1,000 is marginally worse than the OECD average of 7.4.

System Reform. The government is using free-market principles as a key lever to improve efficiency. The 1990 Act introduced three major changes: (a) international market for hospital services, including the separation of purchasing and provision functions; (b) established NHS Trusts

and community units; and (c) allowed budgets for some general practitioners to purchase hospital and other care services on behalf of their patients. The reforms are advancing rapidly, with 95% of hospitals expected to have Trust status.

SWEDEN

Philosophy of the Health Care System. Sweden has a national yet decentralized health system. The Ministry of Health and Social Affairs is responsible for health care laws, while their implementation is largely the responsibility of county councils. The fundamental goals are "good health and health care on equal conditions for the entire population." Policies over the last three decades have concentrated on further decentralization. There are two kinds of local government units in Sweden. County councils on the regional level, and municipalities at the local level. All levels have the right to levy taxes. In 1963, responsibility for primary care was passed to the county councils; in 1967 they were given further responsibility for mental institutions. In 1982, the county councils were put in charge of health promotion and public health, and they soon also took charge of the remaining university hospitals. County councils must promote the health of their residents, offer equal access to good medical care, and plan the organization of health care. In 1991, long term care for the elderly was passed to the municipalities.

Funding of health-care services (other than long-term care) is the responsibility of the county councils, with around 80% of their expenditures for health care, financed partly through regional income taxes. County councils are also supported by state grants, and receive a capitated budget from the national social insurance fund. In addition, the national insurance system is responsible to pay benefits in cash to those insured.

Financing. Spending on health-care in 1990 constituted 8.7% of GDP. This is very high: only the U.S., Canada and France spend a higher proportion in the OECD. In 1988, the three levels of government funded 89% of health-care expenditures: 59% from county council taxation; 7% by

After World War II, a variety of programs were implemented to expand both the supply and demand for health-care services. The most significant was Medicare, which originally provided cost-based reimbursement for hospitals and fee-for-service reimbursements for physicians. At the time, private insurance generally only paid fixed amounts for hospital care and a minimum of coverage for doctor services; however, after the implementation of Medicare, this changed, and the insurers converged on the Medicare system of reimbursement. There were therefore strong incentives for the hospitals and doctors to increase volume and the cost of treatments.

As a result, the health care system expanded rapidly from 1960 to today, with expenditures increasing from 5 to 12% as a percentage of GDP. New technologies and other medical research blossomed, producing sophisticated, high-quality and widely-available care for those with insurance. In 1983, the government moved to pay hospitals a fixed payment for each patient on Medicare with a particular diagnosis. Since government paid for over a quarter of all hospital care, hospitals had an incentive to change. Recently, government replaced the way doctors were paid, allowing them a fee based on the resources expected to be used for any particular service, thus also removing the incentive to increase volume. Private insurers have also responded to escalating medical care costs, typically by moving to managed care.

Financing. Total spending on health care exceeded 12% of GDP in 1990 as shown in Table 1. The U.S. has the highest spending on health care in both absolute and relative terms in the world. The government funded about 41% of health care expenditure in 1991 divided between Medicare (18%), Medicaid (12%) and other government spending at all levels (11%).

Employer-sponsored private insurance covers 59% of the total population. This proportion rises to approximately 70% if one considers only those under 65. Around 4% are covered by a combination of Medicare and their employer's policy. Seven percent of the population is covered by non-group private insurance. There are various non-public sources of funding. Private health insurance, often employer-based, funds around 32% of U.S. health-care expenditure. Non-employer-related private insurance policies are regulated by the states, with each state requiring policies to include certain

benefits. If offered through the employer, exemptions are possible from state requirements. Out-of-pocket payments make up 23% of the funding, while 4% comes from other private sources such as philanthropic donations.

Many U.S. hospitals are "non-profit" institutions, enabling them to obtain many benefits and tax advantages. Non-profit hospitals can finance equipment purchases at lower interest rates, receive donations tax-free, and finance many capital expenditures at favorable rates. Estimates show that non-profits can enjoy about 15-17% savings on operating budgets over private institutions.

Approximately 13% of Americans are uninsured. Medicaid covers 6%, about half of these people. Virtually all Americans 65 years or older are under Medicare, covering 9% of the population. The military and veterans (2%) are separately insured by the government.

Health Care Outcomes. Despite the large sums of money invested in health-care, the US has mixed results. Infant mortality is significantly higher, and both male an female life expectancy at birth are marginally shorter than the OECD average. Various explanations explain these outcomes. Certainly a higher incidence of urban violence is one factor in the lower life expectancy. Improvements in health care also more likely to be applicable to the middle classes rather than the poor; the poor have death rates 44 to 124% higher than privately-insured patients.

System Reform. National health-care reform is currently being debated. The outcome is uncertain.

SECTION IV

PERCEPTIONS OF RUSSIAN CONSUMERS AND PROFESSIONALS

A. INTRODUCTION

The Russian people's beliefs in health care mirror their political outlook for the country and for its political institutions. They are confused about the emerging choices and their role in these choices, and remain concerned on questions of health-care financing. A segment of the population, particularly young people, supports quality care and competition, and accepts greater consumer choice. At the same time, many Russians appear satisfied with the care they receive, and assert that current problems are only temporary.

The juxtaposition of seemingly incongruous statements and opinions from both consumers and providers, then, demonstrates the delicate balance that must be achieved in the public's mind in order to persuade them that reform is both necessary and beneficial. This has significant implications for public education to sweep away cobwebs of ignorance and infiltrate the dark corners of illusions that pervade public attitudes toward reform and privatization.

B. CURRENT ENVIRONMENT

The public at large continues to be quite negative when evaluating the direction of the country, with 61% indicating that Russia is "off on the wrong track." There has also been a marked increase in concern about national political leadership, with 47% of college-educated respondents naming this issue as the top problem. High prices, crime and unemployment also rank high on the list of concerns. Russian's, however, make a clear distinction between general problems facing the nation and those facing them personally, whereas consumers point to the crisis of political leadership as the highest concern this changes to high prices (40%), unemployment (10%) and health care (10%) when they identify issues that directly face them.

Most Russians evaluate themselves as being fairly healthy; only 23% say that they are in poor health, although this may reflect a lack of knowledge of the state of health in OECD countries. Even so, 54% of those over age 65, a large and growing segment of the population, indicate that they are in poor health. A majority of people use and support the role of polyclinics. Only 14% of those who received medical care for which they did not have to pay actually gave providers some type of gift or payment, with the practice being more common in large cities. In terms of quality of care, only 8% evaluate the care they received as "poor," and 90% believe that the quality is "excellent" or "fair."

Nevertheless, the Russian people are extremely concerned about the future of quality health care. These concerns appear greatest in the Far East and in the largest cities, with the best educated and higher income respondents more concerned over issues of quality. Nearly 23% of college graduates have not sought medical care due to quality concerns, and 18% of those in the highest income grouping have stayed away due to quality issues.

C. VIEWS OF THE STATE OF HEALTH CARE

A majority of Russian citizens, both consumer and providers, indicate that they are not satisfied with health care, with 16% saying that they are "not at all satisfied." Consumer opinions match those of providers, with 55% of doctors, nurses, bureaucrats and pharmacists also indicating that they are not satisfied with the current state of health care. However, providers appears to be more negative than the recipients of care. Seventy-eight percent indicate that the system is less secure then ten years ago. The most negative evaluations of the system are more likely from providers in the Far East (83% not satisfied), and Southern Russia (59%). Doctors and administrators tend to be much more negative than such groups as medical technicians or pharmacists. Women providers are more negative, although age is not a major determinant of attitudes on this issue. Over 40% of those who are not satisfied blame "reformers in the government today."

Consumers cite lack of medicine as the reason for dissatisfaction (25%), and this rises to over 40% in the rural areas and with seniors. Other reasons include the rudeness of doctors and general incompetence. Outdated equipment, long lines and waits for care, lack of specialists and high fees are of concern, but at a lesser magnitude. When consumers were asked to list their highest priority, 39% indicated that "keeping hospitals and polyclinics supplied with necessary equipment and drugs" is of greatest concern. This figure rises to 49% in rural areas. Others indicated that reducing pollution should be the government's highest priority (16%). However, their biggest concern personally is money, and over 30% say that what worries them most is the possibility that the "government will run out of money to fund the health care system and we will have to pay more than we can afford for treatment."

In fact, 70% worry "a great deal" that they "might be required to pay" for their family's basic medical care, and an overwhelming 81% indicate that they worry a great deal about not being able to pay for care if a family member "suffered from a catastrophic illness in the future." Long waits for medical care does not appear to be a big problem, with 49% indicating that they "never need to wait" to get an appointment. Waits for care at a facility is less than three hours, with 40% indicating that their wait is one hour or less.

In asking providers, 78% indicated that they feel less secure today about the health care system as compared to ten years ago. Insecurity about the system is highest among those away from Moscow, with 87% in Southern Russia, 83% in the Far East, and 79% in the Urals/Siberia. When questioned about the specific reasons for their dissatisfaction, 39% indicated lack of finances. The solution: a small 6% indicated that having people pay for care was the best solution, while 5% identified changing the system as a whole and 1% support privatization. An amazing 45% of the providers could not think of any way to solve or alleviate the problems they faced.

In asking Russians about the new insurance law, just over half (57%) have seen, read or heard about the insurance law passed last year, an awareness level over 30 points lower than among health-care providers in the country (88%). Awareness among providers is over fifty percent in every region of

the country, and is particularly high in the Fast East area (96% heard about the law). Among consumers, the more educated appear to be paying closer attention to the issue, ranging from 75% for college graduates to 41% for those with less than a high school education. Respondents who are categorized as dissatisfied and more open to reform also appear to be paying more attention to the issue, with 61% of this group having heard about the law. Conversely, awareness drops to 47% among those who are satisfied and resistant to reform. Consumers are also fairly positive in their assessment of the law's impact on health-care, with 38% indicating that the law will improve the health care they receive. This compares to a 29% positive assessment among providers. Providers in Southern Russia and the Far East regions tend to be more positive than their counterparts elsewhere. Age is a strong determinant of attitudes on the issue, with positive assessments more common among younger people. Nearly 48% of the respondents under 45 years of age believe that the law will improve medical care.

On the provider side, awareness of the insurance law is quite high -- 88% However, they are divided over the impact, with 33% of the providers believe that the law will make things worse. Rural providers appear to be most optimistic about the impact with 38% indicating that it will improve health care. Respondents employed in polyclinics tend to be more negative than their counterparts in hospitals or aptekas. The key determinant, however, on the issue of satisfaction is support for the current system. Among those who are satisfied, 34% think that the new law will improve the system.

Consumers were also asked about public education campaigns. Sixty-six percent of the Russian people have heard of the campaigns that promote a healthier lifestyle, ranging from 71% of younger respondents to 58% of those over the age of 65. Unfortunately, this information does not translate into effectiveness. Less than 24% of the respondents who are aware of the campaigns have "changed any habits or do anything differently." The campaign has been more effective with young people (30%), but this level drops to 25% for middle-age respondents. Generally, the public is well informed on the benefits of preventive medicine, and 71% agree with the idea that "it is better to prevent illness by doing things such as seeing a doctor once a year for a physical examination,

exercising and eating rights." The only group which resists the benefits of prevention are almost all older people.

A majority of the Russian public is against individuals paying for health care, although there is about 40% of the population which prefers reform options or believes they are equally as good as the current system. Fifty-three percent (53%) of the public agree with the viewpoint that "people should ever have to pay for medical care as they cannot afford basic care and should only have to pay fore 'extra comforts' such as private rooms or very expensive treatment methods." Twenty-one percent (21%) are more inclined to agree that paying for medical services will create competition among doctors and "force them to provide better quality care while still keeping fees at reasonable rates."

Predictably, older Russians tend to be much more conservative and are more concerned about retaining "free" care. Fully sixty-seven percent (67%) of those over the age of 65 believe that people should never have to pay for care. Of those aged under 35 support of this view is just 40% and actually 29% agree with the idea that paying for services is the only thing that will foster competition and bring up the level of quality.

Less educated respondents are driving the view that health care should continue to be free to patients with two thirds (66%) of those having less than a high school education. No difference in attitudes exist between urban and rural. Russians in Central/Northern region tend to be more supportive of free care (58%) than the Southern (52%), Ural/Siberia (47%) or Far East (51%) region. Women are six points more likely than men to think that care should continue to be free and provided by the government.

A plurality (46%) of the Russian public indicate that they would still go to their local polyclinic even if cost was not a consideration, although 22% indicate that they would go to a local private doctor. Willingness to visit a private doctor drops almost twenty points from the youngest respondents (35%) to the oldest (16%). Even though cost was explained not to be a factor in their decision income still is decisive to their decision.

On the provider side of the equation, 78% state that the current health care system does not meet the needs of the Russian people although remedies identified center around old solutions to their own needs. Nearly 49% of the providers say that increasing salaries is the incentive is the incentive that "should be available". Only 1% suggest encouraging private activity while 3% think an appropriate incentive is allowing self administration of facilities. A majority (69%) support the concept of competition that "would result in better care at lower costs" - the whole concept that is the basis for capitalism and free trade.

Interestingly, 48% of the administrators indicate that they have the power to change the reimbursement system, increasing to 68% of administrators in Central/Northern Russia and 57% in the urban areas.

The current financial system of health care is relatively unclear even to providers. On some issues providers are not capable of even estimating or guessing about the facility's finances. Under 50% of polyclinic employees are able to tell how they receive reimbursement for their services, while only 40% of hospital employees are able to explain their reimbursement system. Since most do not know how they are being financed now it is not surprising that it is difficult for them to predict what impact a solely insurance based system would have on the facility.

Respondents who are employed in a private company, or one that is in transition to the private sector, and who have children, are most open to the concept that patients paying for care is the only way to foster competition and thereby improve quality. A plurality (46%) indicate that they would still go to their local polyclinic even if cost was not a factor, although 22% indicate that they would go to a private doctor. Going to a local polyclinic is the chief preference for respondents in every region, never deviating more than two points from the national average.

Acceptance of private doctors appears to be higher in the Far East region. Age and education play an important role in determining respondents' acceptance of private doctors, with willingness to visit a private doctor dropping almost twenty points from the young respondents (35%) to the oldest

(16%). Even though cost was explained not to be a factor, income is still decisive to their decisions. Willingness to go to a private doctor is 17 points higher among high-income respondents than among the lowest-level income bracket.

Geographically, rural respondents are much more open to the idea of seeing a doctor at a nonprofit institution, with 63% indicating willingness to visit a health trust facility. But openness drops to 52% of urban residents. Southern Russia respondents are open to this new type of facility. Age continues to play a major role, with openness to visiting a health trust facility decreasing as age increases. But the addition of the word "for profit" has an interesting effect on some key groups in Russia. The concept detracts from the facility's marketability among rural areas (54%-9%) particularly among those in Southern Russia. However, this injection of capitalism slightly enhances support among urban residents. Openness to these reformed institutions does not change in Central/Northern Russia.

The addition of the "for profit" has the greatest negative impact on the older people, with a full 10 point change from being supportive of a nonprofit for the aged group 65 and older. Conversely, fully 67% of college graduates and 60% technical school graduates would visit a doctor at a private, for-profit facility.

D. THE FUTURE AND POSSIBILITIES FOR REFORM

With all the worries expressed about the health care system, it is somewhat surprising that Russians are as optimistic as they are when asked to predict the future of the system. The public generally speculates that the health-care system will get better (32%) rather than deteriorate (21%). Russia's youth tend to be driving the optimistic predictions for the health-care system. Optimism also tends to increase with income of the respondent with just 27% of low-income respondents indicating that health care will improve. Yet, a surprisingly high (54%) agrees with the statement "The health care system we have in Russia is an inherently good system, and the current problems are only temporary." This view tends to be more dominant in rural areas (60%), than with urban residents.

It is above 50% in every region of the country, and the view is fairly widespread with little deviations based on gender, age, or income.

Among respondents who are satisfied with the current system and resistant to change, fully 74% agree with the idea that the problems are only temporary in nature. By contrast, those who are dissatisfied with the current system and support some type of reform disagree with the idea that the problems are only temporary.

In looking at value choices, a majority (55%) of Russians indicated that "keeping medical care free to all Russians" should take precedence over "making sure the quality of health care you and your family receive is the best it can be even if it means paying something." Here, age is the key determinant of attitudes, with those aged 18-34 supporting quality care over free care (57% to 38%), compared with those over 65 years old supporting free care (82%) over quality care (13%). More educated voters are also much more likely to demand quality care, even if it comes at some costs to them personally. Half of graduates from technical schools and 55% of college graduates indicate that quality care is more desirable than free care. This contrasts sharply with the attitudes of less-educated respondents.

Providers and consumers support the concept of limiting universal health care. While they differ on the list of what items should be paid for by the patient, both agree that restricted universal coverage will increase quality care (60%-36% among consumers). Providers believe that the government should pay for psychiatric care (98%), while 31% of consumers support payment for these services. Providers also think that patients should pay for contraceptives (66%), but only 35% of consumers agree. Preventive exams are viewed as appropriate for basic care, but abortion and optometric care are widely seen as the patient's responsibility.

Those most dissatisfied with the current health-care system and those most open to reform comprise 46% of the Russian people. They are:

- From Urals/Siberia or Far East regions;
- in towns less than 10,000 people;
- aged 18-34 years old;
- women under the age of 45;
- people with children;
- college or technical school education;
- "white collar" workers;
- people who think health-care system problems are inherent, not temporary; and
- people who used unpaid and paid medical care in the past two years.

Clearly, there are still fears to be overcome with the group that is more open to change, but there are promising signs throughout the data with this group on reform issues. For example, while 60% of the group that is satisfied and opposed to reform indicate that individuals and businesses running health-care facilities and the pharmaceutical industry would make health care unaffordable to most Russians, less than half (49%) of the dissatisfied respondents agree with this assessment of privatization. Indeed, 27% assert that things will improve. They are less likely to put a premium on free care for all Russians, and more willing to accept restrictions on care in return for better basic medical care.

Another indication of support for reform is overall support for the concept of an insurance-based system (57% support, 22% oppose), although 18% of providers thought that insurance would result in a deterioration of their facility. Even stronger support for health "trusts" exists (78% support, 7% oppose). This evidence clearly indicates that reform leading to choice and competition is desired.

Consumers were asked to choose between two opposing points of view about privatization, and just over half (52%) take a negative view of the situation and agree that "allowing individuals and businesses to run the health care system will only make health care unaffordable for most Russians while letting these people get rich off our misery." Just 23% of the public takes a positive view of privatization, arguing that "allowing individuals and businesses to run Russia's hospitals and

pharmaceutical companies will make hospitals be more responsive to their patients' needs and eliminate the widespread inefficiencies of the state run system through healthy competition." Geographically, there is substantially more support for a private health care system in the Far East region of the country than in other areas. Southern Russia and Central Northern regions tend to be the weakest areas.

Thus, one must be careful in the rhetoric employed to rally support for the privatization process. The term "privatization" per se, conjures up negative images for this group. While 39% of the satisfied group assert that "privatization is always a bad thing" agreement with this statement jumps up to 47% with those in the dissatisfied group.

Finally, there is mixed emotion over the issue of Western pharmaceutical companies being allowed into the Russian market. The idea that the Western companies are merely taking a situation ripe for exploitation, and making money out of other peoples' misery tends to be the prevailing feeling among older men (49%), blue collar workers (47%), low income respondents (48%) and those who think the health care system is going to deteriorate (48%).

Forty-five percent of consumers disagree that "Western companies who are coming to Russia to sell drugs and medical equipment are only exploiting our people and should be barred from this market," while 42% agree with this statement. Fifty-nine percent of consumers believe that Russian doctors are better than Western doctors, even without modern drugs and expensive equipment.

SECTION V

THE NEW APPROACH TO RUSSIAN HEALTH CARE

A. THE KEY PRINCIPLES OF THE NEW APPROACH

Having assessed Russia's current health-care problems, examined the current system, and gained a better understanding of the perceptions of both consumers and providers, we now turn to the new approach. Progress should be made rapidly to avoid further deterioration in the quality of medical services while the health-care system is reformed. The proposed guiding principles are straightforward:

a) meaningful universal access to
b) enhanced, efficiently provided, cost-effective health care through
c) increased consumer choice and competition among health-care providers, leading to
d) better health and greater satisfaction for the Russian people.

To ensure meaningful universal access to a basic package of health care, existing Russian resources must be allocated more efficiently. Although increasing the share of GNP in the health-care field is a long-term objective (while also bearing in mind the need to keep costs down), in the short term, such an increase is highly unlikely. In practice, therefore, in the near future, a better and more productive allocation of resources is the most likely way to uncover "new" human resources and funding. Moreover, increased cooperation and network-building among providers, such as between hospitals and polyclinics, will also be an important factor. Otherwise, the rationing of health care that presently exists in the form of long waits for diagnosis and treatment, and scarcities of important pharmaceuticals and medical supplies, will continue and possibly worsen. This means using the existing pool of well-trained medical manpower more effectively, and, through additional training, redirecting attention from tertiary to primary health-care.

Virtually all observers of Western health systems agree that preventive medicine should receive far greater stress than it does currently, and the same can be said about the Russian system. The highest priority should be given to non-infectious diseases, which cause 96 out of every 100 deaths in Russia. For example, better dietary practices and a better life style including more exercise can lead to healthier, longer and more productive lives, thus mitigating the existing burden on health-care providers. Reducing alcohol, drug and tobacco abuse through changed societal perceptions of these substances, brought about by widespread public education campaigns will be especially important. Timely diagnoses of damage to the teeth and oral cavity will prevent many somatic diseases. Environmental protection standards should be enhanced, especially in industrial areas. More sanitary, hygienic and safer workplaces will likewise reduce the need for expensive curative measures for Russians exposed to the risks of air and water pollution and accidents. Extensive public health initiatives in all of these areas will be required, and governments at all levels will continue to have significant roles.

Efficiently-provided and cost-effective health care at all levels -- prevention, early detection of illness, treatment and rehabilitation -- is also critical to achieving a "Healthy Russia 2000." Efforts should be made to avoid the problems many Western systems encountered by excessive expenditures on "high tech" machines and treatments that result in large financial commitments but limited curative benefits. Lessons can be learned from the "moral hazards" created by Western insurance systems and tax codes which encourage excessive consumption of health care by those covered. Because large amounts of new resources for health care are unlikely in the near future, efficiency, cooperation and cost effectiveness must be central to health-care reform in Russia.

Increased consumer choice and competition among providers will be strong engines in pulling the health-care system into the future. Providers will have much stronger incentives to be responsive to health care consumers, who in turn will have a range of options now unavailable to them. Physicians in Western health-care systems, for example, are acutely aware of the impact of competition on their own level of attention to their patients' needs. The practice of providing medical services for fees should be broadened (whether covered by government or private insurance,

or by direct payment by the consumer), in parallel with the continued provision of health care by the government. Physicians and other providers in fee-for-service practices will understand that their incomes are determined by the extent of their output, not simply by putting in the requisite number of hours each day in a polyclinic. There should even be scope for compensation based not just on production, but *quality* as well, as in the system in Yekaterinburg. These changes will require extensive public education for both consumers and providers, but the benefits over time will be well worth the expenses for such campaigns. Consumers who become aware that there are affirmative steps they can take to stay healthy and that there are options his provider should offer him will be empowered consumers, expressing their own authority.

Better health is the final objective, leading as it will to longer lives, greater consumer satisfaction and a stronger sense of well-being and security. With all of the travails and social hardships imposed on the Russian people by the transformation and reform of other sectors of the economy psycho-social stress is itself a cause of poor health. It is, therefore, vital that reform in the health-care system not be seen as simply adding one more burden. This is both a humanitarian and a political imperative. Personal and family health contribute to individual self-confidence and social stability. The difference in life expectancies between men and women must be reduced, along with a reduction in the infant and maternal mortality rate. Children in particular must be of special concern, both for their own healthy futures and for the satisfaction and confidence of their parents and other relatives. They must receive <u>all</u> necessary physical and moral education. For the elderly, there must be a sharp drop in the number of days lived at less than full potential due to acute and chronic diseases.

These principles establish the broad outlines of a "Healthy Russia 2000." They should win broad acceptance both among the Russian people as a whole, and among the providers of health care. They emphasize the importance of Russian efforts and Russian strengths, building on what is already sound in the health-care system.

B. POLICIES AND STRATEGIES DERIVED FROM THE NEW PRINCIPLES

Russia's population is large enough to support an internationally competitive health-care industry. The population is well-educated, and includes a strong scientific community. Within a system that provides appropriate incentives, and which provides clear and unambiguous legal structures, the future of the Russian health-care industry can be bright, satisfying the needs and aspirations of the Russian people. As noted at the outset, reform is already underway, through pilot projects and local initiatives which need to be fostered and spread across the country.

Privatization and market-oriented policies are the techniques most likely to achieve such a result, while also accommodating (a) the different types of care and technology; (b) the nature of health-care financing; and (c) a wide variety of local circumstances across Russia. Moreover, privatization legislation must also encompass a regulatory framework that will (a) protect the consumers from private monopolies at any level; and (b) protect the financial viability of investors operating in a highly uncertain economic environment.

"Healthy Russia 2000" recognizes that not all of the changes recommended can be made at the same time throughout Russia. It also recognizes that reform of many aspects of health care will have to be handled differently from reform in other sectors of the Russian economy, for obvious political, economic and social reasons. Finally, careful consideration will have to be given to the preparation for privatization in those areas where privatization seems advisable. Where not advisable, governments should nonetheless strive to achieve better systems management and operation. Moreover, governments -- national, regional and local -- will continue to have important medical and legal roles, such as in the fields of public health; the provision of care for especially vulnerable groups such as the elderly and the truly needy; scientific and medical research and education; protection of intellectual property rights; and others. Even there, however, the incentives and disciplines of market-oriented policies and strategies should be used where feasible. Financing mechanisms, where the national government will continue to have a major role, are discussed in the next section.

Physicians should be permitted and encouraged to practice privately, either alone, in partnership, or in privatized polyclinics. Patients should have a choice among physicians and other providers, who would be compensated based on the amount and kind of services they provide. Large polyclinics (those with 200 or more employees) might be broken up into smaller, more specialized, privately-owned units (operating on the same premises), including those which supply administrative and technical support to care providers. In St. Petersburg, one large polyclinic did elect to break itself into smaller functional units, with positive results. That model, however, may not be applicable everywhere, and providers should be given the choice of which approach to pursue.

Hospitals and other major medical facilities can be denationalized in several ways. First, control and governance over the hospitals can be handed over formally to local, regional and municipal governments. This process of decentralization is already well under way on a de facto basis, and the shift needs largely only de jure endorsement. Even when government ownership and control is maintained, decentralizing such control will bring hospital management closer to the needs of local populations, hopefully making them more responsive to actual conditions on the ground. Pilot projects are already underway, working with reform-minded hospitals and polyclinics to enhance efficiency and financial management, and perhaps even move toward privatization.

Second, straightforward privatization should be encouraged and supported. For-profit hospitals in Western countries provided the highest-quality health care with the same concern for the well-being and comfort of their patients as do government-owned hospitals. By bringing businesslike practices such as careful inventory control, electronic data processing, and labor-saving technology to bear on health care, for-profit chains and individual hospitals have brought costs down while enhancing care. For-profit hospitals, for example, tend to have shorter stays for their patients, which results in health benefits for the patients and economic benefits for the hospitals.

Third, privately-controlled not-for-profit or "charitable" hospitals should also be encouraged and supported. These could be "owned" by civic charities, labor unions, religious orders, fraternal societies, academic institutions, and similar organizations, and perhaps enjoy tax-exempt status as

in many Western countries. In this regard, Russia might well also chose to create "Self Governing Hospital Trusts" ("SGHTs") through the denationalization of State hospitals, as the United Kingdom, Israel and the Scandinavian countries have recently done. Through this process, hospitals become "public trusts," which are not-for-profit organizations. This status essentially removes management of the institutions from government hands.

Whichever model is adopted at the conclusion of the policy debate -- for-profit hospitals, not-for-profit hospitals, as well as those still owned by national or local governments -- would run on variable incomes derived from the sale of services rather than on fixed budgets supplied by the government. Because money would thus move with the patients, hospitals must focus their energies on the quality of their medical care and patient satisfaction if they are to remain viable. Under this system, control over the allocation of health-care funding of hospitals shifts from bureaucrats and hospital consultants to those who purchase the services in the community.

Hospitals or polyclinics that remain under government ownership should have the option of contracting out management functions to the private sector. This would maximize efficiency, and keep costs down, thus benefiting consumers. There has been worldwide success with privatizing hospital management, food services, laundry and linen services, equipment supply and maintenance, and specialized medical services such as radiologists, anesthesiologists and medical laboratory services. For those hospitals which choose not to contract out, existing managements should receive enhanced training in the necessary skills.

In the fields of pharmaceuticals and medical devices, conditions are such that rapid privatization and openness to foreign investment and trade at the manufacturing, wholesale and retail levels are prospects for very rapid implementation. Projects are already underway to encourage American pharmaceutical manufactures to seek increased trade and investment in Russia, and legislation is ready for debate. Additional similar measures can be instituted immediately to attract foreign investment and enhance the indigenous Russian pharmaceutical industry. Foreign investment could also help spread the utilization of "good manufacturing Practices," as defined by WHO.

Privatization and the application of competitive forces would promote the unobstructed flow of needed pharmaceuticals and devices. In addition, greater attention would be focused on the costs of production and distribution, and drugs would be more widely available, thus lessening the demand for more intensive and expensive forms of medical intervention.

Pharmaceuticals and medical devices are sufficiently analogous to other industries being privatized that options and methods previously utilized can be applied here as well. For example, it will be important in any privatizing legislation to protect against the expropriation of privatized enterprises by the government, against invidious treatment of foreign interests and investments, and against restrictions on the expatriation of earnings and the free sale of property within Russia. Obviously, the enabling legislation would also have to take into account the particulars of this industry.

Especially important here is the creation of adequate safeguards to ensure the protection of intellectual property rights. The law on Foreign Investments in Russia guarantees to foreign-owned enterprises at least the same rights to intellectual property as apply to Russian citizens and enterprises. Care should be taken that these protections are consistent with international standards and practices to avoid "free riders," which would strongly discourage foreign trade and investment, and which would inhibit the formation of joint ventures between Russian and foreign investors. Moreover, the existing "caps" on producer, wholesaler and retail prices are misallocating resources, and should be promptly eliminated.

Privatization would help create a well-functioning, cost-effective pharmaceutical manufacturing sector by overcoming an inadequate manufacturing base, obsolete production facilities, an antiquated and excessively complex range of products, inefficient organizational structures, and inadequate quality controls. In addition to privatization, however, other policy changes are needed to create a climate for "Healthy Russia 2000." Internationally recognized production and quality standards should be established and enforced, and needless barriers to the introduction of new therapeutic agents should be eliminated as rapidly as possible. The Russian government should decide on a list

of essential drugs based upon those already promulgated by the World Health Organization, and use the Russian list to provide incentives for privatized operations to meet pressing needs.

In distributing and retailing pharmaceuticals and medical devices, Russia now has monopolistic control at the wholesale level, inefficient distribution methods, and economically insecure retail facilities. Indeed, many outside observers believe that the distribution system is perhaps the single most pervasive block to an effective pharmaceutical sector. Major restructuring, on an urgent basis, should begin immediately. The government should encourage further competition and investment in this vital area, including by foreign investors, requiring as a condition of licensing that the wholesaler carry a full line of needed therapeutic agents, as just noted. The government should also consider "bundling" geographically-dispersed wholesalers for privatization, with the aim of creating national wholesale businesses. Having as few restrictions as possible (e.g., freely granting wholesale licenses) is a way to achieve a competitive and efficient distribution system. It will, in any case, be more expeditious, especially if foreign distribution groups are allowed to apply for licenses.

Privatized retail pharmacies should not have the continuing incentive to dispense high-cost products where less expensive alternatives are available. Reimbursement on the basis of a uniform, negotiated dispensing fee would reduce that incentive. In some countries, ownership of pharmacies is limited to licensed pharmacists. Such a restriction would simply inhibit beneficial competition. The formation of chain operations, which lower costs because of economies of scale, would be inhibited, a less-than-optimal result. Private entrepreneurial skills at both the wholesale and retail levels are currently lacking, and substantial training and support will be needed to inculcate private-sector methods.

These general policies and strategies, which flow directly from the principles of a new approach to health care, provide "Healthy Russia 2000" with a bold agenda, filled with challenges and opportunities. They reflect the hopes and aspirations of the Russian people, as our surveys have discovered, and provide a roadmap for the future.

C. FINANCING OF HEALTH CARE

Russia inherited a system in which the Government financed, managed and operated health care. Through 1991-1992, the last years for which full information is available, health care was financed almost entirely from general revenues of the Federal and local governments. The bulk of these funds was allocated through the Ministry of Health and local health authorities, and accounted for an estimated 82% of total health expenditures in 1991. Unfortunately, there were really three levels of quality of care under the old system. The nomenklatura and a few others had exclusive care facilities. Below that level was care for employees of important Soviet ministries and state-owned enterprises. The remaining financial resources accommodated the vast bulk of the population.

However, new health insurance legislation ("HIL") became operational in 1993, creating far-reaching reforms in the health financing system. The HIL creates a non-budgetary channel of resources, and establishes a mechanism for pooling and allocating public money dedicated to medical care. HIL implementation is slow and unstructured, partly because numerous issues remain unsettled. These include: (a) defining a basic basket of care; (b) establishing a capitation formula; (c) specifying government financial liability for health; (d) creating regional equalization mechanisms; and (e) establishing reimbursement methods for the provision of care. The proper role of private finance also remains uncertain, depending on decisions on privatization. Private finance, including voluntary insurance, is unquestionably growing. Here, however, we consider mostly public finance.

Timely solutions for these issues will create financial mechanisms and appropriate incentives for promoting better health, equity, efficiency, and client satisfaction. If not timely however, there is a serious risk that HIL funds could be wasted, without bringing about real change, thereby missing an historic opportunity for the Russian health-care system. Russia needs solutions which are feasible in the short term, which would contribute to long-term solutions based on Russia's own experience.

The HIL's central institutional feature is the creation of separate, compulsory medical insurance ("CMI") funds at the Federal and territorial levels to manage revenues from a wage tax, and Federal and territorial governments' contributions. The funds are independent, non-commercial finance and credit institutions (thus separating health-care financing from the actual delivery of services), responsible for collecting the major part of funds from employers and local authorities. The Federal CMI fund is to achieve cross-regional equity, but there are no clear guidelines how.

The actual purchasing of care for consumers is handled by two types of institutions which would be contracted by the Regional Health Insurance Funds ("RHIFs"). The legislation recognizes "insurers" (sick funds and insurance companies, and branches of RHIFs). Insurers will be reimbursed on a capitation basis. The law allows public insurers to perform either by using salaried personnel in their own medical institutions, or by buying services from independent care providers, thus acting as health maintenance organizations or as brokers with providers. The development of insurance companies has been erratic, with wide variations among the regions. Moscow has approximately twenty insurers licensed under the CMI, is a very competitive market, and 100% of the local CMI funds are dispersed through the insurers. In Archangelsk, by contrast, there is only one licensed insurer, exercising a monopoly position.

Territorial CMI funds manage care on behalf of consumers where insurance companies do not exist or are underdeveloped, thus permitting public administration to manage care, but not necessarily to provide it. This configuration may be most suited for rural and sparsely populated areas. Virtually all CMI funding now goes ultimately to hospitals, but a limited number of polyclinics may be covered by early 1995. Here again, however, there are wide variations. Novgorod and Barnaul, despite a shortage of funds, started hospitals and polyclinics simultaneously. Moscow actually began with polyclinics, and CMI funds currently provide almost 50% of polyclinic expenses.

Under voluntary insurance programs, individuals and employers are able to select the insurance companies of their choice. It is still unclear what the respective roles of CMI funds, local health authorities and insurance companies are in monitoring costs and the quality of health-care delivery.

As in so many other areas, there are significant regional variations. In Tver, the CMI fund is very strong and active, whereas in Novosibirsk it is almost nonexistent. These differences, needless to say, make management planning difficult.

Capitation, as opposed to direct budgeting, depends on two interrelated preconditions: competition among providers, and informed choice by consumers. Capitation is based on pooling risk and paying by "averages" for homogeneous groups. Such averages cannot and should not include compensation for low-probability situations with high costs, such as epidemiological and natural calamities. The same is true for rare diseases calling for expensive treatment. Provision and careful regulation must apply to such situations, either through general revenues or special reserves.

Provision of care will be through competing providers, but ownership is flexible. Thus, care could be provided through government facilities, the private sector or physician cooperatives. Providers would be reimbursed through a predetermined fee schedule negotiated (based on operations performed, cases treated or capitation) by the local health authorities, professional associations, and insurance companies.

The legislation offers citizens three levels of choice. The first is the right to enroll in any insurance company or sick fund they wish, without going through an employer. They are also entitled to change insurers or sick funds periodically. The second level of choice is among alternative care providers as stipulated by the "insurer" of choice. The third is to permit increased private payments on a fee-for-service basis.

Employers' contributions are 3.6% of wages, of which 0.2% is paid into the Federal fund and 3.4% is paid into the territorial funds. The earmarked payroll tax is paid directly to the regional and Federal funds rather than to insurers; the tax is not intended to reduce revenue allocations for health from regular government budgets. All sources of finance are pooled in each oblast under the newly established RHIF, which is financed through general revenues, the CMI tax, and equalization funds (if any). Where possible, these will pay insurers, who will in turn procure care from providers.

Most health public finance, estimated to be 55%, is still provided from Federal and local general revenues, at least in the near term. A second part, an estimated 30%, will come from the CMI paid by employers (including government and other budgetary organizations). Private expenditures and private insurance funds will likely grow as tax revenues and government budgets remain sparse. These private co-payments are important not only as sources of additional revenue, but also because they encourage individuals to develop some financial responsibility for their health.

With no displacement, the additional funds (if prudently managed) would help the Russian health care system to maintain its 1991 levels of real resources, although the moneys allocated to the federal fund would not suffice for equalization of health finance across regions.

From a cost-containment perspective, it is desirable to prevent upward swings in levels of health finance. From a service availability perspective, it is desirable to prevent downward swings which may follow high rates of inflation. Stability in levels of finance is desirable. Consequently, real levels of health finance need to be set periodically, taking into account the health of the population, technology, and the state of the economy.

While the local government must transfer funds to the RHIF as an employer, its contribution or liability for the non-employed remains undefined both in levels and mechanisms. The HIL states that local governments are responsible for the equitable care of the unemployed. This might be interpreted as providing that government is responsible for the unemployed according to the same financing principles applied to the employed, thus implying that wages and the health tax rate determine total public-finance levels for health. Because of fluctuating surpluses and deficits, therefore, the system's stability could be at risk, although mitigation is possible by creating a reserve to be financed through surpluses. Real levels of health expenditures would be set through a capitation formula. Here the budget from general revenues rather than the earmarked tax is pre-set, and any surplus in the CMI tax is used to create a reserve.

SECTION VI

IMPLEMENTING THE NEW APPROACH

A. NEW LAWS AND REGULATIONS

The general legislative framework for decentralizing and privatizing the Russian health-care system is already in place through the Privatization Law as adopted on 3 July 1991, and amended on 5 June 1992 and several subsequent statutes and presidential decrees. Needed now -- and very quickly -- are new laws and regulations specifically addressing the particular needs of the coming health-care system. Moreover, the traditional health-and-safety regulatory system that surrounds health-care systems around the world must be maintained and strengthened.

Given the difficulties in public financing of health care, specific legal and regulatory regimes for a private insurance system -- which do not now exist -- need to be written and promptly implemented. Perhaps even more important for the economy as a whole, but critical to workable insurance programs, viable financial markets must be created as a matter of urgency.

Already designated for privatization according to Presidential Decree Number 2284 (24 December 1993) are: hospitals, polyclinics, most university health-care facilities, pharmaceutical and medical equipment manufacturers, and almost all of the wholesalers and retailers of pharmaceuticals and medical devices. Prohibited from privatization are: certain advanced medical training centers, scientific research institutions; orphanages, nurseries and homes for the elderly.

For those entities and enterprises open to privatization, the general process is already well-established: (1) valuation of the assets to be privatized to determine the initial sale price and level of authorized capitalization; (2) developing applications for privatization leading to operational plans on how to privatize; (3) the bidding and sales process to determine who will actually own the privatized enterprise once sold; and (4) the actual transformation of state and municipally owned enterprises into joint-stock status.

Careful procedures targeted on the unique aspects of the health care system will be required. Valuation of a polyclinic, for example, may be difficult because the principal asset will be the quality and skills of the actual health-care providers, a highly intangible asset to value. Similarly, privatization funds (whereby employees accumulate assets so they can ultimately purchase equity interests) must be tailored to the highly diverse participants in health care. A privatization fund for a pharmaceutical manufacturer may be very different than a fund for a hospital or polyclinic. Physicians in private practice may require legal forms, such as the "professional corporation," with legal implications quite different from a standard joint stock company. The utility of partnerships and sole proprietorships, for pharmaceutical retailers and others, for example, should not be overlooked.

For those facilities and entities which are not privatized, new legal forms will also need to be created. Hospitals, for example, could be owned by local governments as "municipal corporations," a concept largely unfamiliar in Russia at present, but one that would preserve government ownership while nonetheless encouraging depoliticization and sound business practices. Analogous creations ("Federally-chartered corporations") would also be appropriate where ownership of institutions is preserved at the national level. Legislation authorizing ownership and management of health-care facilities by non-governmental organizations is necessary and clarifying the rights and obligations of the directors and employees of such organizations is important.

Virtually all observers of the present Russian health-care system believe that privatization alone is not enough. Indeed, in the absence of other reforms, privatization might fail, with enormous adverse political consequences. For example, replacing public monopolies with private monopolies would not represent progress. Thus, the manner in which state-owned enterprises are restructured and divested must be undertaken with future competitive and antitrust conditions very much in mind. Geographic monopolies could be avoided, as noted earlier with respect to pharmaceutical wholesalers by grouping existing local monopolies for divestiture in such a way that nationally-competitive firms are created. Another example is that, for pharmaceutical retailers, enabling legislation should make clear that they are entirely free to sell non-pharmaceutical products,

thus strengthening their competitive bases. After privatization is completed, vigorous antitrust enforcement against price-fixing, collusive market allocation and other unacceptable practices must be undertaken. Market forces will ultimately become workable, but the critical starting point is to prevent private monopolization in the early stages, avoiding adverse economic and political consequences.

We have earlier noted the importance of intellectual property rights, and a related point, especially for pharmaceuticals, is the need to eliminate the present inefficient system of price caps and subsidies. This system infects both the entire pharmaceutical industry and the structure of hospitals and polyclinics. Without doubt, eliminating it will cause disruptions and inconveniences, but doing so upon privatization will minimize such problems. Indeed, there is a strong argument for eliminating the subsidies and caps even before restructuring so that the system can begin to adjust as soon as possible.

Doubtless, even more new legal structures will be needed as the process of building "Healthy Russia 2000" proceeds. We should not wait, however, until all of the necessary legal structures are in place before proceeding. Statutes and regulations should follow policy decisions to proceed, not the other way around. Once the policy debate is concluded in each area, programs for the drafting of enabling statutes and regulations, valuation of assets and restructuring should be initiated as soon as practicable, with foreign cooperation if desired.

B. ARRANGING FINANCING

Government responsibilities involve: setting policy, providing information, ensuring competition, and financing research and training. Once again, since decisions on the role of the private sector remain to be made, here we largely consider public financing, especially the CMI. Nonetheless, a multiplicity of funding sources appears the most desirable way of increasing scarce resources. The real level of per-capita expenditures on health for 1991, before major economic and administrative

changes affected the health system, should be the benchmark, a first objective for recovery and stabilization. There should be no mistaking that even this level will be difficult to achieve.

The CMI's basic program defines the volume and conditions of providing medical and pharmaceutical care for all Russians, including a minimum amount of medical care in twenty-nine specialities. Territorial programs are developed on this basis, and their volume cannot be less than volume of the Federal program. This program includes: (a) primary medical care (polyclinic care), including emergency and preventive care; (b) hospital care; and (c) pharmaceuticals provided in hospitals. For pharmaceuticals provided in polyclinics, people will generally pay from their private funds or through insurance. Special arrangements have been made as follows: (a) enterprises would pay for treatment of occupational poisoning and acute professional diseases; (b) private funds and CMI contributions would pay fees for needed medications and medical supplies by hospitals and polyclinics; and (c) Federal funds would pay for "expensive" care (e.g., transplanting organs and cardiovascular surgery).

Since the HIL's passage, Russia's efforts to define a basic package of care have been substantial, and generally are in line with similar OECD efforts. The basic problem, however, is that these efforts are detached from any systematic assessment of financial feasibility or affordability. The Russian reality is that critical resources are fixed in the short term, posing very grave risks to the quality of facilities, provider motivation, quality of service and care, and the ability of the system to reform. While CMI collection effectiveness should continue to increase, it is unclear how much further its rate of effectiveness can climb.

There are four possible "solutions" to the resource problem: (1) local governments allocate funds for health care sufficient to cover costs for the non-employed; (2) local governments allocate the same percentage of the Local Gross Product allocated in 1990, in addition to local revenues from the earmarked HIL; (3) local governments supplement the money collected through the wage tax so that the two combined amount to the 1990 share of health local economy; or (4) private payments

increase. Extensive modelling diagrams on financial flows and equilibrium possibilities are contained in Annex III.

All these solutions pose economic and political problems. Raising taxes -- even very slightly -- in the face of a falling (or stable, but low) GDP risks impairing other sectors of the economy. Moreover, the state of the economy itself will make it very difficult for enterprises and governments to collect adequate CMI taxes, even if the tax's effective rate is increased. Increased private payments in a troubled economy will also not be easy. Reallocating existing tax revenues toward health care and away from other priorities may be difficult to impossible as a matter of practical politics. One other possibility would be relatively high national taxes on tobacco and alcohol. Such taxes might both raise money (which could be earmarked for health care), and produce beneficial life-style changes.

There is, unfortunately, also a fifth "solution" -- continued declining real expenditures on health until the economy fully stabilizes, and then begins to expand. Increases in the unemployment rate, for example, would not only have deleterious consequences for the economy as a whole, but would reduce CMI collections as well, thus imposing further constraints on health-care financing. This result would be highly undesirable, but its possibility must be recognized.

Given the scarcity of resources, there is a public interest in avoiding "overinvestment" or underutilization of capital, which fuels inflation in medical-care costs. Capital costs generate less concern at the level of primary care (where investments are usually small) than at higher levels, where large investments are required, particularly for new and expensive technology.

Therefore, governments tend to control large capital investments in their health-care systems. Such control may range from requiring "certificates of need," as has been done even for private investment in the United States, to establishing a government monopoly on such investments (as in Canada and Sweden). However, because providers may substitute other goods or services for those regulated, it is not at all clear that overall costs are actually controlled. Moreover, the market power of existing

hospitals may be increased if competitors cannot make capital expenditures. Innovation may also be reduced if competition decreases. If the government remains the sole source of financing for certain investments, it will be difficult to sever the link between the public budget and the so-called "public hospitals."

Another alternative is more efficient use of existing capital resources, or diverting them to other health-related uses. A significant example would be accelerating the change from hospital-based care to outpatient treatment. At present, the annual cost-per-bed in hospitals ranges from $3,000 to $11,000 across the regions, and there is little or no incentive to cut overcapacity or allocate resources to out-patient care. Changing these incentives should mean that unnecessary (and underutilized) beds could be eliminated, and the freed-up buildings and space used for more productive purposes. Intensive utilization reviews would speed this process. Many of the same financial concerns applicable to capital expenditures also apply to financing medical research. Many of the same uncertainties exist as well, with substantial financial implications, and short- and long-term answers may differ.

C. TRAINING THE WORK FORCE AND MAINTAINING THE QUALITY OF CARE

Reforming the health-care system will require significant changes in thinking and skills in a number of categories. We focus here on three areas: management and business skills, medical education, and quality of health care. These in particular demonstrate why "Healthy Russia 2000" is a work in progress, and not a static model.

Management Skills. General management skills must include a philosophy of management, organization, decision making, delegation, and empowerment. Management information systems are another major component, dealing with case mix, quality assurance, pharmaceuticals and related inventory management, and general financial applications. Financial management is specially important as institutional autonomy is encouraged, and in fact appearing at all provider levels.

Health-care financing includes concepts of risk, insurance, and co-payments. Information must be available to a variety of providers. Medical Information Systems should include general financial applications, appointment scheduling, case management by type of illness and data collection. Marketing in the broad sense includes promoting wellness and prevention of disease. Consumer satisfaction includes pleasing the consumer, but also providing improved care. Consumer participation in public-provider planning, insurance funds, and other related activities will be accomplished.

Management-education programs for physicians and administrators should proceed immediately in three areas:

- Development of a core curriculum in management. The comprehensive postgraduate management program being developed by the Moscow Medical Academy is an excellent example, and should ultimately be adopted by other major learning centers. The program should not be restricted to physicians, but should encourage lawyers, economists and other potential administrators to participate.

- Sharing information and experiences among various regions of Russia is critical, including starting a Russian journal of medical management.

- Continued exposure to and examination of international innovations such as the American International Health Alliance cooperative effort between hospitals in Russia and the United States, is useful.

Teaching programs should include a very wide spectrum of opportunities. Actual and potential leaders should participate in six-to-twelve month programs in public health, hospital administration, and health planning, either at institutions such as the Moscow Medical Academy or externally in programs leading to the equivalent of MPH or MBA degrees. Short-term courses can also be

arranged, focusing on management skills. Other special training areas include family-planning programs and social marketing relating to accident prevention, alcohol abuse and smoking.

Programs should be developed for individuals or small groups of physicians who need increased management skills because of market incentives and privatization, ranging from cost accounting, consumer relations and marketing to more sophisticated requirements.

Medical Education. New standards are being developed for medical and continuing education. But with the current state of decentralization in the health system, it is difficult to say if new centrally-imposed standards will be accepted in the oblasts. There unquestionably needs to be some change in the system if the providers are to be efficient and responsive to real health care needs.

Russians are very interested in the concept of family practice, which would widen the scope of practice of their current low-level doctors, the "technicians," and improve its efficiency. It could also lead to improved provider-consumer relationships, and better patient satisfaction.

Medical school curricula should be reviewed on a continuing basis so that obsolete material is replaced by more contemporary subject matter. Additions to the program should include evaluation of quality, medical economies, and a greater emphasis on preventive medicine. Exchange problems with more progressive foreign institutions should be facilitated. Medical texts should be updated where useful through grants for revision or development, and translation where useful. Computer literacy should be stressed. The dissemination of medical literature is very uneven throughout the nation. A Russian and/or English language journal of abstracts with access to the originals by fax as required is potentially easy and inexpensive.

Special attention should be paid to change the size and composition of the physician and nurse work force away from the dominance of hospital treatment to a more appropriate emphasis on outpatient care and preventive medicine. A complement to the expanded role of the therapist-pediatrician will be further raising the standards of specialists. Improving the current system of specialty training

could also lead to improved quality of care. The present informal system, which seems to be more like a system of fellowships, has produced a very mixed quality of specialist. The system of specialty training and recertification must be improved to make it more flexible and more responsive to community needs. There should be collaboration with the various Russian professional organizations in these efforts.

Extending the current postgraduate training period from 1-2 years to 2-3 years should be encouraged. Continuing medical education will remain important, allowing an opportunity for extended postgraduate retraining in general practice and in advanced specialty training. Postgraduate education would also be broadened to include family planning, preventive medicine and evolving technology in continuous quality enhancement, medical management, and consumer participation.

Nursing education should be restructured based on redefining the role of the nurse. Nursing education will be enhanced as the role of the physician is elevated, including increased skills in examination and case management. Home nursing will be a new application of these skills.

Quality of Health Care. Quality of health care is key to judging the effectiveness of health care reform. Providers are very sensitive to issues of quality. The current system for physicians emphasizes detection of outliers and punishment for gross or repeated offenses, but is often complicated by concealment and favoritism. A new system with greater flexibility and participation should be developed to elevate the care of all physicians in a process of selecting, measuring and responding to local quality issues. Key features involve: 1) identifying the appropriate system of quality improvement; 2) putting in place necessary data gathering and information sharing; and 3) integrating the process in health-care education. We propose:

- Practice parameters to be developed by physicians under the supervision of the Russian Academy of Medicine. Each Oblast/city/ insurance company would develop an independent Quality Assessment body composed of providers, public officials, consumers, and employers

to provide broad supervision and monitoring, assuring that each provider would operate effectively, and that outputs and outcomes are appropriate.

- Continuous Quality Improvement teams of providers. Their function will be to define customers, identify processes, select and prioritize indicators of performance and monitor, document and modify.

For polyclinics and hospitals, there is already quality assurance activity. These quality programs are usually hierarchical or autocratic, often very detailed, and frequently punitive. There is little opportunity for consumer input. If the system is to become effective, some overall quality guidelines and standards must be developed, and they could be modeled after the accreditation systems set up for hospitals and outpatient clinics in the U.S.

There must be management training in quality assurance systems for polyclinic and hospital administrative personnel. The principles of quality management and improvement, which depend more on consensus building than autocratic control, must be introduced. There should be input from Russian professional organizations, especially the organization of chief doctors, to design a new framework for quality assurance, as well as to consider financial factors and operational efficiency.

Mechanisms for obtaining both consumer and provider input into the issue of quality should also be developed. One direction would be to form community boards, employer alliances, and women's interest groups. An important aspect of quality is whether care is relevant and appropriate to community needs. Are the public health issues, such as environmental problems and preventive measures, being adequately addressed by the health care system? Is care accessible and affordable to all?

There must be a means to gather and analyze demographic, epidemiologic and utilization data. There must also be local committees, comprised of consumers, providers, government, and industry, which can review this data, and make decisions on the direction the health care system should take

to improve the health of the community. Public health guidelines should stress these bottom-line aspects of quality.

D. PUBLIC EDUCATION CAMPAIGN

The polling data shows the importance of undertaking a public education campaign in order to build consumer and provider support for health-care reform. Without such a campaign it will be difficult to undertake needed changes without unduly alarming the general population about their personal health, and the role of the government in meeting their needs. Nevertheless, the Government of the Russian Federation should not necessarily accept the status quo of public opinion. Political leaders should lead where their convictions take them.

Objectives. The overall campaign should focus on solidifying the support from the population that is most interested and supportive of change in the health-care system. This group includes 46 % of the Russian population; namely, young people, women under 45, those with children, from rural areas, particularly in the Urals/Siberia and the Far East, those who believe that the system is fundamentally flawed, those with higher education and higher incomes, and those who use both paid and "free" medical care.

Once this group has been mobilized a strong base of support will exist to support the reform process. Thus, while 55% of the Russian people support "keeping medical care free to all Russians" more than "making sure of the quality of health care" even if it means paying some costs, the base of support for quality care, competition and choice remains substantial. Even on the fundamental question of coverage for universal health care, 33% of the population disagreed with the concept, and 60% agree to restrictions on health care if it resulted in better care.

The objectives of a public education campaign, then, include:

- increase the citizens' sense of responsibility for their own health care;

- build support for health-care reform with consumers and providers;
- develop new Russian health-care institutions, and utilize existing Russian institutions to carry out communication activities designed to build public support;
- ensure that the benefits of health-care reform, including concepts of privatization are known and supported through national communication vehicles;
- provide training and assistance in the establishment of health-care associations and develop mechanisms to create an advocacy health-care industry supportive of competition, choice and incentives;
- provide public education through written materials and mass media to explain reform, and demonstrate improved access to quality heath-care services and the efficiencies of market-oriented decision making;
- assist the GKI in framing a national debate within the government, Duma, and the public and provide input from consumers to make more likely the overall success of the effort;
- highlight the pilot programs' success as models for the future; and
- conduct benchmark polls and surveys, focus groups and interviews to measure changes in public attitudes toward health care reform.

Program Elements. The overall communication program must reflect domestic political realities. It must recognize the current state of public opinion about privatization and new issues that will be raised in reforming the health-care system. The program must build short and long-term support that reinforces the positive elements of universal health-care coverage but introduces, and formalizes the introduction, of issues of choice, competition, efficiency and quality. This communication program would be substantially different from traditional media activities. It would focus on the two key audiences -- consumers and providers -- and would focus on building institutional support, the development of associations that would serve as vehicles for future health-care communication activities.

The program must be future-oriented, focused on preventive education, mobilizethe various advocacy groups in the medical community to create an "echo chamber"in order to reinforce themes proposed. It must also:

- address the worries of Russians about financing the health-care system, and introduce the concept of "trust" to a public skeptical of past government roles, and reinforce to the public that universal heath-care remains the bedrock of the Russian health-care system;
- build understanding for consumer-related issues such as quality, competition and choice, reinforce that as the reform process moves forward the security associated with better quality health-care means a more productive, happier Russian family;
- educate the target populations about activities in other Eastern European countries and elsewhere about consumer choice;
- explore curriculum development for all levels of schooling and utilize trained cadre to promote acceptance of health-care reform;
- consider local activities such as Health-Care Road Shows for local communities, "how to" communication manuals for local associations, polyclinics and others; and
- explain why increased competition among providers will result in better quality health-care at a lower cost to consumers and the government.
- test support for reform systems, such as support for an insurance based system and "health trusts".

Essentially, the program would have two mutually reinforcing approaches. The national program would focus on overall themes supporting the reform process, and introduce concepts that inform and motivate. This might take the form of television programming, and public service announcements and commercials. After focus group studies, a theme would be developed identifying the program with the positive aspects of health-care reform. Based on that slogan/logo, the ad campaign would be targeted to the youth and to factual concepts about health-care reform. Real universal health-care coverage would remain a pillar in this ad campaign.

Because of the importance of national radio and television throughout Russia, a national campaign must be used to provide the questions and answers that the Russian people will undoubtedly have about the reform process. The statistical data indicate that maximum local Russian participation should guide the development and implementation of all phases, highlighting the positive elements of the Russian health-care system, and challenges Russians will need to face for better health-care. The media markets for the likely target cities should be saturated.

The second element includes regional and grassroots programs responding to local requirements and concerns. We know from the polling data that various regions have had different understandings about the reform process. Accordingly, four regional offices should be set up to carry out programs responsive to these different orientations. Thus, in Southern Russia, the campaign should be more cautious and incremental in educating the population about changes in the current system. In the Far East, by contrast, different messages should be sent to a population that is much more strongly supportive of reform.

An important element of the program is to highlight the successes that are currently taking place throughout Russia. This means using the pilot projects and vignettes that we have identified and demonstrating that these are the models of the future. Thus, we must prove vividly through actual, reform-minded polyclinics, hospitals, and pharmacies that change is occurring, and that people are benefitting from these changes.

A one-year program should commence immediately, putting a team in place with Russian counterparts and Russian institutions to begin the creative process. Development of provider and consumer advocacy groups should be initiated, coupled with television, radio, and newspaper announcements supporting health-care reform, in order to ensure a "Healthy Russia 2000."

E. ACHIEVING CONSENSUS: A PRESIDENTIAL COMMISSION

An effective and frequently used means of achieving public understanding and support for major government initiatives is the appointment of a Presidential Commission. American history offers some particularly relevant examples concerning health and social services such as President Roosevelt's 1934 appointment of a cabinet-level Committee on Economic Security, whose report a year later proposed what ultimately became the U.S. Social Security program.

A major governmental initiative such as health care reform will have enormous effects on a country's economy and the lives of its people. Along with substantial support could arise substantial misunderstanding and opposition. The establishment of an authoritative, visible and accessible Presidential Commission can inform the process, clarify the Government's objectives, and enable potential opponents to have their views understood and considered. Thoughtfully done, a Commission's appointment, deliberations, research and resulting proposals on health care for Russia could have these effects:

- It could provide decision makers with an independent source of information about the existing health-care system. The information contained in "Healthy Russia 2000" could be used as a first step by the Commission;

- It could enlist the support of highly qualified and recognized Russian experts in health care as members of the Commission itself or as researchers or consultants to the Commission;

- It could make clear to the Russian people the Government's determination to conduct a careful and open assessment of the existing system and alternatives for change, and provide a sound rationale for the Government's proposals; and

- It could, as noted, help to defuse opposition by encouraging potential opponents to present their views to the Commission both in writing and in open hearings.

In our view, an ideal structure for such a commission would have these characteristics:

Membership. The Commission's makeup could be solely government officials, solely distinguished private citizens, or a combination of the two. We recommend the third alternative, with a heavy weighting in favor of distinguished and independent outsiders able to "tell it like it is." The Commission should not be large and unwieldy. Less than ten members would seem ideal.

Staff Support. Essential staff are experts in health economics, financing, insurance coverage, clinical medicine, epidemiology, medical facilities, medical training, human resources, information management, pharmaceuticals and medical supplies. Staff should include skilled writers and a public information officer. The commission should be able to hire on a full or part time basis consultants, researchers and other technical experts needed to fulfill its mission. The staff should have quarters and equipment adequate to its needs.

Public Access to the Commission. Early on, the Commission should hold public hearings on critical issues in health-care reform. In contrast to membership, these hearings should be as broadly inclusive as possible. No major and responsible point of view should be excluded. No interested group should be able to say it was unable to make its views known to the Commission. Ideally, the hearings should be conducted at several sites within Russia, and should give Commission members opportunities to visit medical facilities throughout the country. Hearings should be made part of the public record of the Commission and summarized as part of a final report.

Research. Along with public hearings, the Commission's staff should carry out relevant research to inform its findings and proposals. The group should research health-care facilities, work force, training, financing, organization, and related issues. Very importantly, the Commission's report should provide a comprehensive factual background for its recommendations, especially noting the successes of the pilot projects around the country.

Timing. How long it takes for the Commission to accomplish its task depends among other things on the ability of the Government to form the necessary structure, the depth of research to be conducted, and the intensity of pressure to achieve a useful result. Experience suggests one year as a reasonable time. Less time would mean less research and possibly less public involvement.

The Commission's Report. The Commission's findings and proposals should not be lost in an encyclopedia of health information. Ideally, the report should have two parts: a final report and a volume of background papers. The separation does not imply that the research and other supplemental material are unimportant. The research will be an enormously valuable resource to those charged with implementing the emerging program. At a minimum, the final report should include:

- a letter of transmittal to the President;
- a summary of major findings;
- a summary of recommendations and proposals;
- separate chapters on each of the major issues considered, including those outlined elsewhere in this paper;
- an acknowledgment of those who contributed to the report as consultants or participants in hearings or other meetings of the Commission or Advisory Council; and
- a list of the Commission and Advisory Council members and staff.

Even after the Commission issues its report, it could continue in being to provide periodic progress reports, accentuate successful reforms., and highlight major problems that remain to be overcome. Experience in the United States has shown the value of such efforts at critical times in the nation's life. There is every reason to believe that the same salutary effect could be achieved for "Healthy Russia 2000."

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ВВЕДЕНИЕ

Среди потока программных документов, обрушивающихся на Москву, "Здоровая Россия - 2000" уникален. Реформа здравоохранения уже началась, но с большими различиями в регионах. В соответствии с этим, любые программные документы должны учитывать характерные особенности уже идущих изменений. Ни рекомендации, ни исследование общественного мнения, ни эконометрическая модель не являются самоцелью, они - только рубежи на пути реформы здравоохранения. В действительности - это рабочий документ, разработка которого уже началась, и которая обязательно будет продолжена по мере начала изучения и внедрения рекомендаций, изложенных в документе.

В Разделе I документа "Здоровая Россия 2000" представлены четыре возможных варианта будущей российской системы здравоохранения. В настоящий момент есть возможность достижения (а) универсального осмысленного подхода к (б) развитой и эффективной системе здравоохранения через (в) увеличение возможности выбора для потребителя и конкуренцию между медицинскими учреждениями, что приведет к улучшению здоровья и удовлетворению потребностей жителей России. Особое внимание будет уделяться всем четырем составляющим системы здравоохранения: профилактике, ранней диагностике заболеваний, лечению и реабилитации. Некоторые аспекты здравоохранения (например: производство фармпрепаратов, дистрибуция и розничная торговля) могут быть полностью приватизированы. Другие учреждения, такие как больницы и поликлиники, получат более широкие возможности: они могут остаться в собственности государства, перейти под контроль местного правительства, управляться некоммерческой организацией или быть приватизированы.

Раздел II описывает общее состояние здровья населения России, которое, в двух словах, оставляет желать лучшего. По сравнению со странами ОЭС, продолжительность жизни в России короче, выше уровень заболеваемости и смертности среди трудоспособного населения; выше уровень детской смертности; а также отмечается общее ослабление иммунитета населения из-за загрязнения окружающей среды, злоупотребления алкоголем и аллергии среди молодежи. Уровень рождаемости понизился, уровень смертности увеличился: население стареет. Молодежь, женщины, а также престарелые - это наиболее уязвимые группы населения, а мужчины имеют наименьшую продолжительность жизни, как и в других Европейских странах.

Раздел III документа "Здоровая Россия 2000" описывает современное состояние системы здравоохранения в свете вышеупомянутых проблем. Причиной многих проблем, с которыми сталкивается здравоохранение России являются всеобщие

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трудности перехода от старых структур и методов к новым. При том, что количество медицинских учреждений больше небходимого, они находятся в плачевном состоянии. Количество врачей и медсестер достаточно большое, но их способности не используются достаточно эффективно (очень часто они расходуют свое время на немедицинские вопросы), а зарплата и престиж профессии невысоки. Серьезный дефицит медицинского оборудования осложняется недостаточным финансированием для покупки новой, первоклассной аппаратуры. Обеспечение медикаментами гораздо ниже необходимого уровня. Заводы устаревшие, отсутствует производственая экспертиза на некоторые виды лекарств, ассортимент не отвечает современным потребностям. Распределение фармпрепаратов является одной из серьезных проблем во всей системе здравоохранения, которая требует серьезных изменений также как и розничная торговля. Традиционно система здравоохранения финансировалась по остаточному принципу, а сейчас поступления из национального бюджета только сократились. Несмотря на принятие закона об обязательном медицинском страховании (ОМС), доля поступлений от частных источников составляет маленький процент от общих расходов на здравоохранение. В результате, реальные расходы на здравоохранение сокращаются. Таким образом, современная система здравоохранения страдает нехваткой общественного финансировния, а также до сих пор не смогла привлечь частные ресурсы в количестве, достаточном для удовлетворения существующих потребностей. Краткий анализ голландской, немецкой, британской, шведской и американской системы здравоохранения позволит читателям и лицам, ответственным за принятие решений, сравнить существующую российскую систему и возможные альтернативы.

Раздел IV описывает результаты первого систематического опроса потребителей и поставщиков медицинских услуг. Мнения по поводу адекватности существующей системы здравоохранения и необходимости реформы сильно разделились. Среди молодых, более образованных людей превалирует неудовлетворенность существующей системой, они больше готовы платить за более высокий уровень обслуживания, по сравнению с пожилыми, менее образованными россиянами, которые предпочли бы оставить систему такой, какая она есть. Также существуют большие региональные различия. Медицинский персонал оказывается гораздо более осведомлен о ОМС, чем потребители. Не смотря на существующие кампании по общественному просвещению, направленные на улучшения образа жизни и, таким образом, здоровья, на самом деле в поведении населения происходят очень маленькие изменения. Тем не менее, большинство россиян оптимистично настроены по поводу будущего здравоохранения, и значительное большинство поддерживает основные реформы в системе.

Раздел V описыват новый подход к российской системе здравоохранения, подчеркивая то, что повышение эффективности и наличие конкуренции приведут к более целесообразному использованию скудных ресурсов, особенно в связи с тем,

что общее количество средств, предоствляемых здравоохранению едва ли вырастет в ближайшем будущем. Должно быть уделено особое внимание профилактической медицине и предоставлению пациенту возможности выбора. Фармацевтическое производство, распределение и розничная торговля должны быть приватизированы, должны быть созданы коммерческие и некоммерческие поликлиники и больницы, а также медицинские учреждения, принадлежащие новому местному правительству. Система ОМС должна работать более эффективно, а также должны быть исследованы источники частного финансирования.

Раздел VI предлагает конкретные меры для внедрения нового подхода, некоторые из которых уже применяются. Дополнительные шаги должны быть сделаны немедленно, в то время как некоторые другие должны быть отложены до результатов дебатов о системе здравоохранения, ожидаемых в ближайшем будущем. Понадобятся основательные новые законы и инструкции для определения новых частных и местных правительственных учреждений которые будут созданы, для предотвращения появления новых монополий. Финансирование остается проблемой, но должны быть предприняты конкретные шаги для осмысленного подхода к всеобщему медицинскому обслуживанию. Критическим моментом является подготовка рабочей силы и поддержание качества обслуживания. Значительные усилия потребуются для изменения фармацевтической промышленности, особенно распределения. Более эффективные кампании по общественному просвящению необходимы для успеха программы реформ. Наконец, Комиссия Президента должна создать общественную поддержку этим начинаниям.

РАЗДЕЛ I
БУДУЩЕЕ РОССИЙСКОГО ЗДРАВООХРАНЕНИЯ

Граждане России стремятся - и заслуживают - иметь систему здравоохранения , равную по качеству системам других развитых промышленных демократических стран, и отвечающую задаче, поставленной Всемирной Организацией Здравоохранения - "Здоровье для всех к 2000 году". Слишком долго граждане России не имели адекватной системы здравоохранения из-за того, что политика была рассчитана на достижение идеологических целей. Скудные ресурсы тратились впустую, а состояние здоровья российских граждан ухудшалось. Ключевые решения по проблемам здравоохранения принимались правительственными бюрократами, не подотчетными никому, а не самими гражданами. В результате, российское здравоохранение находилось в плачевном состоянии. Однако, сегодня открываются новые возможности обновления системы, которые необходимо использовать.

Сегодня существуют возможности достигнуть следующего:

- реальная общедоступность
- большая эффективность здравоохранения
- расширение возможностей выбора для потребителей и конкуренции для специалистов-медиков, что приведет к
- более полному удовлетворению нужд россиян.

Эта возможность, которая будет осуществлена посредством кардинальной реорганизации здравоохранения, является проблемой особой важности для правительства России. Без сомнения, это будет значительная программа, которая будет учитывать существующие политические реалии и объединит в работе всех тех, кого беспокоит судьба и здоровье России.

Приниципп **общедоступности** здравоохранения, хотя и существовал теоретически раньше, но на практике часто не соблюдался из-за существовавшего фаворитизма, неравенства распределения людских и материальных ресурсов, а также неэффективности. Постоянная нехватка средств, так как здравоохранение не было первоочередной сферой финансирования из государственного бюджета в Советском Союзе, сказывалась на качестве. "Общедоступность" стала еще одним политическим лозунгом, прикрывающим реальные недостатки и дефицит. Программа "Здоровая Россия - 2000" сделает принцип "общедоступности" реальностью, а не просто риторической фразой. Российские граждане будут иметь реальную возможность влиять на состояние здравоохранения, а специалисты-медики будут иметь дополнительные стимулы и дополнительное финансирование для системы. Уже сейчас здравоохранение имеет значительный приток хорошо обученных медицинских профессионалов, которые могут быть использованы более эффективно.

Обеспечение эффективности медицинских услуг является центральным моментом в новой системе. Введение усиленного контроля и правила о том, что решения будут приниматься клиентами, медицинскими работниками и организациями, которые оплачивают медицинские услуги, как доминирующих принципов в системе здравоохранения, - от больницы до оптоввых и розничных торговцев фармацевтической продукцией, - повысит эффективность и прибыльность почти незамедлительно. Все это обеспечит действительно эффективное лечение для всех. В 4 широких сферах профилактической медицины: ранней диагностике болезней, медицинской помощи и реабилитации - программа "Здоровая Россия - 2000" обеспечит лучшее качество услуг для россиян, снабжение декарственными препаратами и другой медицинской продукцией.

Увеличение выбора для потребителей и конкуренции среди специалистов является одним из важнейших моментов в реорганизации российского здравоохранения. Программа "Здоровая Россия - 2000" обеспечивает людям возможности, в то же время предусматривает увеличение конкуренции между специалистами и создание для них дополнительных стимулов посредством прочного партнерства между государственным и частным сектором и преимуществ рыночной системы. Программы, нацеленные на общественное просвещение в области новой системы здравоохранения, обеспечат доступность адекватной информации как для потребителей, так и для специалистов - медиков. Высококачественная продукция и услуги будут больше отвечать запросам потребителей.

Более полное удовлетворение запросов потребителей должно стать главной задачей любых реформ здравоохранения в России. Реорганизация финансового, юридического и других аспектов здравоохранения должна проводиться с четким пониманием того, что конкретные люди, престарелые, женщины, дети и другие группы населения, должны выиграть в результате этого. Программа "Здоровая Россия - 2000" рассчитана не на привилегированные властные структуры, а на обычных россиян, представителей всех слоев населения и жителей всех регионов.

Что касается **профилактической медицины** в этой области Рассия значительно отстает от большинства промышленных демократических государств. Во многих странах профилактике уделяется все большее внимание, как по причине внимания к состоянию здоровья каждого конкретного гражданина, так и потому, что это снижает затраты на лечение. Гораздо более эффективно со всех точек зрения предотвратить болезни, чем лечить их. Так, например, необходимо улучшить состояние окружающей среды и питание в России, сделать рабочие места более безопасными, снизить потребление алкоголя , табака и наркотиков, - все это должно быть предусмотрено в

программе "Здоровая Россия - 2000". Только эти шаги приведут к улучшению здоровья населения и повышению производительности работающего населения.

Ранняя диагностика болезней также может иметь значительное влияние на благополучие каждого конкретного человека и материальные затраты. Лечить болезнь до того, как она обострилась, лучше для пациентов и их семей, это снижает материальные потери в экономике, и это, в целом, дешевле. Это имеет особое значение для детей, в случае с которыми ранние и периодические обследования и вакцинация имеют важное значение для их здоровья и приносят экономическую выгоду. Так как российская система была рассчитана на лечение в больницах, будет необходимо внести значительные изменения. С этой точки зрения, конкуренция между врачами, поликлиниками и другими лечебными учреждениями будет очень важна, и ударение будет делаться на раннюю диагностику болезней. Также будет важно все эти принципы подкрепить политической программой.

Лечение , безусловно, должно оставаться в центре внимания программы "Здоровая Россия - 2000". Сделать больницы более эффективными, так чтобы имеющиеся ресурсы использовались для предоставления лучшей медицинской помощи и большему количеству граждан. Важными элементами программы станут повышение конкурентноспособности больниц при их передаче во владение частным компаниям, негосударственным организациям, муниципалитетам, при приватизации поликлиник, предприятий по производству фармацевтических препаратов и медицинского оборудования - все это станет важным фактором при проведении необходимых реформ. Повышение эффективности здравоохранения поможет снизить затраты как потребителей, так и медиков.

Реабилитация остается важной частью здравоохранения, но и она также нуждается в изменениях. Появятся новые возможности в результате ожидаемого снижения значения больничного лечения, так как новый механизм оплаты лечения поможет уменьшить срок пребывания в больнице, и одновременно поможет повысить жизненный уровень пациентов, одновременно снижая затраты на здравоохранение.

Без сомнения, выполнение программы "Здоровая Россия - 2000" будет сопряжено с трудностями. Важным фактором выполнения программы является общее состояние национальной экономики. Существуют значительные различия между регионами России в области качества медицинских услуг, в ресурсах (финансовых, технологических, человеческих, организационных), в методах финансирования. Значительное недофинансирование наблюдается по всей стране, особенно в условиях,

когда государственный бюджет существует в сложной макроэкономической среде. Новые планы страхования только отчасти выполняются и их жизненность предсказывать еще рано.

Необходимо рассматривать и внедрять совершенно новые юридические и нормативные структуры, при внедрении новых моделей собственности, коммерческих операций и налогообложения. Стандарты качества для медицинских услуг и товаров необходимо отрегулировать и улучшить. Необходимо убедить западных партнеров, что серьезные реформы возможны и требуют привлечения значительных внешних ресурсов. Необходимо также убедить потенциальных иностранных инвесторов в реальности торговли и инвестиций. Общественное доверие и вера в преимущества и важность реорганизации необходимо поддерживать. В Государственной Думе должна существовать сильная коалиция поддержки.

Программа "Здоровая Россия - 2000" включает полное понимание препятствий, которые необходимо преодолевать, и трудностей, с которыми придется столкнуться. Тем не менее, при выполнении программы "Здоровая Россия - 2000" специалисты не собираются отступать перед трудностями. Это будет честно по отношению к жителям России, которые упорно работают над созданием демократического, свободного, процветающего общества. Существуют доказательства того, что высокий и увеличивающийся уровень смертности в бывшем Советском Союзе были одной из главных причин нестабильности режима, а значит и разрушения коммунистической диктатуры. Но высокий уровень смертности может повлечь также и нестабильность российской молодой демократии и возврат к старому времени. Необходимо избежать этого, и нет поводов для пессимистических прогнозов.

Более того, процесс реформирования уже начался, хотя и фрагментарно и спонтанно. Во многих местах уже десятилетиями существуют частные аптеки и частная врачебная практика. Поликлиники и больницы просят консультаций по приватизации. Идут пилотные проекты во многих сферах медицины по всей России, что покажет преимущества реформ. Значительная часть полномочий и ответственности перешла от центральных органов власти к местным. Уже начали работать механизмы медицинского страхования и финансирования за счет средств страхования (общественных и частных). Эти усилия предпринимаются даже в условиях значительных экономических, юридических и материально-технических трудностей, и успех этих усилий в значительной мере будет зависеть от изменений в здравоохранении.

Программа "Здоровая Россия - 2000" предусматривает одинаковое отношение ко всем аспектам здравоохранения. Некоторые области (производство,

распределение и розничная торговля фармацевтическими препаратами) здравоохранения должны быть приватизированы как можно скорее. Тогда, как другие (больницы) могут иметь несколько вариантов реорганизации, от коммерческих организаций до негосударственных орагнизаций, освобожденных от уплаты налогов и организаций, находящихся в ведении муниципальных или региональных органов. Однако, факт остается фактом, реформы необходимо начинать немедленно, основываясь на уникальном опыте и знаниях России и на ожидаемых успехах следующего десятилетия.

Программа "Здоровая Россия - 2000" содержит описание современного состояния российского здравоохранения (Раздел 2) и объясняет существующую систему здравоохранения (Раздел 3). Программа анализирует результаты широких исследований мнений российских потребителей и профессионалов медицинских услуг и то, что эти высказывания могут рассказать нам о существующей ситуации и будущих перспективах (Раздел 4). Наконец, программа "Здоровая Россия - 2000" содержит описание нового подхода к здравоохранению (Часть 5), и то, как он будет внедряться (Раздел 6). Приложения содержат дополнительную информацию и описание необходимых ресурсов.

РАЗДЕЛ II
СОСТОЯНИЕ ЗДОРОВЬЯ В СОВРЕМЕННОЙ РОССИИ

Российская Федерация - это многонациональное государство занимающее территорию более 17 миллионов квадратных километров, с общим населением около 148,600,000 человек. Семьдесят восемь процентов населения проживает на Европейской территории, 22% в Азиатских регионах и 73.3% из них - городское население. По сравнению с развитыми странами, состояние здоровья в России можно охарактеризовать следующим образом:

- пониженная средняя ожидаемая продолжительность жизни;
- высокий уровень заболеваемости и смертности среди работоспособного населения (особенно среди мужчин) от сердечнососудистых и онкологических заболеваний, несчастных случаев, отравлений, ран, убийств и самоубийств;
- высокий уровень младенческой смертности;
- высокий уровень заболеваемости и смертности от болезней дыхательной и пищеварительной системы, а также инфекционных заболеваний в детских и молодых возростах;
- ослабление иммунного статуса населения вследствие загрязнения окружающей среды; алкоголизация населения, аллергизация детей и подростков.

Коротко, здоровье населения Российской Федерации находится в плачевном состоянии и продолжает ухудшаться.

В различных регионах различны уровень и структура здравоохранения. Эти различия наглядно видны в следующих регионах:

- Районы с традиционно развитой промышленностью, широкой социальной инфраструктурой и сложной экологической ситуацией: Северо-Восточный, Центральный и Уральский экономические районы.
- Районы с развитой промышленностью, в которых большая часть населения сосредоточена в местных центрах, а остальная территория слабо заселена, с тяжелой экологической ситуацией и неблагоприятными природными условиями: Северный, Восточно-Сибирский и Дальневосточный экономические районы.

- Сельскохозяйственные/индустриальные территории с неблагоприятной экологической ситуацией в сельской местности (например вследствие неэффективного применения пестицидов и удобрений, или полохой организации скотоводческих ферм): Волго-Вятский, Центрально-Черноземный и Поволжский экономические районы.

- Основываясь на общем анализе показателей здоровья, опасными можно назвать следующие регионы: Тува, Хабаровский край, Сахалинская область, Кемеровская область, Иркутская область, Красноярский край, Республика Коми, Магаданская область, Томская область, Новгородская область.

Также существуют различия между районами по уровню заболеваемости и смертности. Например, в 1992 году уровень смертности в России составил 12.2 на 1,000 человек. Этот показатель составил от 9.6 на Дальнем Востоке до 14.3 в Центрально-Черноземном районе, в то время как различие между административными территориями варьируется от 5.7 в Чукотском национальном округе до 16.6 в Псковской области. В 1993 в первый раз в послевоенной истории, количество родившихся было меньше количества умерших, население сократилось на 800,000 человек.

В 1993 г. уровень младенческой смертности составил 19.1 на 1,000 новорожденных, тогда как в Странах западной Европы он составляет 7.4. Показатель варьировался от 15.6 в Северозападном районе до 20.8 в Западно-Сибирском районе. На областном уровне эти различия еще более заметны: от 14.1 в Карачаево-Черкесской республике до 32.3 в Туве. Регионильные различия также хорошо видны из показателй заболеваний и смертности от инфекционных, паразитарных, онкологических заболеваний, болезней пищеварительной системы.

После 1992 уровень рождаемости снизился с 10.7 до 9.2 на 1,000 населения, уровень смертности увеличился с 12.2 до 14.6 на 1,000 населения; в тоже время количество умерших от травм и отравлений увеличилось в 1.4 раза по сравнению с 1992 годом. Главные причины смертности - эндогенные заболевания (заболевания кровообращения, злокачественные новообразования и некоторые другие). Например, в Мурманской области уровень рождаемости снизился с 19.9 в 1990 до 7.2 в 1993, а общий уровень смертности вырос с 7.5 в 1992 до 9.9, уровень патологий связанных с употреблением наркотиков увеличился на 25.4%.
Снижение уровня рождаемости и увеличение уровня смертности среди трудоспособного населения приведет к увеличению количества пристарелых

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среди населения. В результате возрастет количество пациентов, требующих постоянного обслуживания.

В области профилактики, приоритет должен быть отдан предупреждению неинфекционных заболеваний, так как они являютс причиной 96 из 100 смертей. Высокий уровень госпитализации и долгое пребывание в больнице (по крайней мере 24 дня в терапевтическом и 13.5 в хирургическом отделении) наводит на мысль об особенно низком уровне превентивной и первичной помощи, не смотря на то, что уровень госпитализации снижается (с 25.5 на 100 человек в 1985 до 21.8 в 1993). Высокая смертность от инфекционных заболеваний, по сравнению с развитыми странами, в широком масштабе, является результатом неблагоприятных условий жизни, которые также вызывают неинфекционные заболевания:

- Нездоровый образ жизни (плохое питание, в частности недостаток протеинов, витаминов, растительных жиров, пищевых волокон; курение, злоупотребление алкоголем, и недостаток физических упражнений);
- Неблагоприятные экологические факторы, особенно в промышленно развитых областях;
- Неблагоприятные санитарно-гигиенические условия на производстве.
- Психологический и социальный стресс, обусловленный социально-экономическими трудностями переходного переода;
- Ухудшение качества медицинского обслуживания в период перестройки системы здравоохранения.

А. ОСНОВНЫЕ ЗАБОЛЕВАНИЯ

Инфекционные заболевания. По сравнению с развитыми странами, уровень острых кишечных инфекций, таких как сальмонеллез и вирусный гепатит, выше, особенно в регионах с неблагоприятной социальной, экономической, санитарной и экологической обстановкой (Дагестан, Чечня, Ингушетия, Сибирь, Тува и Бурятия).Тува занимает одно из первых мест по количеству заболеваний гепатитом "А" и "Б", а также кишечных заболеваний. Количество заболеваний дифтерией и корью продолжает увеличиваться во всех административных областях, особенно в пренаселенных городах, таких как Москва и Ст.Петербург. Только количество заболеваний дифтерией выросло в 1992 на 110 процентов. Не прекращаются детские заболевания такие как коклюш, корь, полиомиелит.

Средний уровень заболеваний туберкулезом (который теперь рассматривается как социальное заболевание) составляет 34.2 на 100,000 человека и различается от региона к региону : от 23.1 в Северном районе до 83.7 в Туве. Наивысший уровень заболеваемости туберкулезом был зарегистрирован в Поволжском, Северо-Кавказском и Западно-Сибирском районах. Треть больных тубуркулезом диагностируется уже в запушенном состоянии, что указывает на необходимость профилактических мер.

Растут заболевания природно-очаговыми инфекциями. Ведущее место среди зоонозных инфекций занимиет геморрагическая лихорадка с почечным синдромом которая распространена в 45 административных территориях России. Но в наибольшей степени в Башкортостане, Удмуртии, Республике Мприй-Эл. На территории России продолжают действовать природные очаги туляремии (в основном в Центральном, Центрально-Черноземном и Волго-Вятском районах). На урбанизированных территориях активизируются очаги лептоспироза, например, в Санкт-Петрбурге. Природные очаги клещевого энцефалита установлены в лесной зоне на 38 административных территориях, однако 85-90% заболеваний выявляются на Урале, Западной Сибири, на Дальнем Востоке.

Паразитарная патология (опосторхоз, дифиллоболтриоз и др.) остается ведущей среди народов Севера, Дальнего Востока и Северного Кавказа, в значительной степени определяя состояние здоровья в этих регионах. Рост заболеваемости сифилисом, гонорреей и другими венерическими заболеваниями, педикулезом, часоткой является индикатором социального неблагополучия общества.

Онкологические заболевания. Рост заболеваемости раком в России связан как с постарением населения, общим ухудшением экологической ситуации. Необходимо раннее диагностирование. Среди онкологических пациентов количество больных с диагнозом рак второй или первой степени составляет 35.8%. В России количество больных "преинвазивным" раком составляет 0.4 из каждых 100 пациентов со злокачественной патологией.

В 1992 г. было выявлено 271,6 случаев злокачественных опухолей на 100 тыс. населения. В структуре онкологической заболеваемости мужского населения первые места занимают рак легкого (28,6%), желудка (15,8%), кожи (7,6%), гемобластозы (4,5%); женского - рак молочной железы (17,4%), желудка (12,4%), кожи (12,3%) и шейки матки (5,8%). Мужчины заболевают в 1,8 раза чаще чем женщины. Максимальные уровни заболеваемости населения в целом отмечаются в Сахалинской области; у мужчин - в Магаданской, Новгородской и Мурманской областях; у женщин - в Калининградской и Челябинской областях, Туве и Адыгее.

Наиболее высокие показатели заболеваемости раком легкого и ее более быстрый рост зафиксированы в Европейской части России в таких промышленных областях как Ленинградская, Нижегородская, Челябинская.

Сердечно-сосудистые заболевания. В РФ среди всех причин смерти в 1992 г. болезни системы кровообращения занимали первое место. Показатель смертности по России составил 646,0 на 100 тыс. населения. В структуре смертности основное место занимают ишемическая болезнь сердца и цереброваскулярные болезни, в структуре заболеваемости наряду с указанными значительное место занимает гипертоническая болезнь. Около 30 случаев смерти от сердечно-сосудистых заболеваний приходится на трудоспособный возраст (20-59 лет). По грубым подсчетам 15 процентов детей школьного возраста страдают повышенным давлением. Массовый контроль над гипертонией, своевременное диагностирование повышенного давления, регистрация липопротеидной патологии, а также сокращение факторов риска сократит уровень сердечно-сосудистых патологий.

Психическое здоровье. Психические заболевания, включая наркологические расстройства, устойчиво входят в число распространенных заболеваний среди населения России. Уровень впервые в жизни выявленных психических расстройств (безалкогольных психозов, хронического алкоголизма, наркомании, токсикомании) составил в 1992 г. 106,6 на 100 тыс. населения. Уровень впервые в жизни выявленных алкогольных психозов, хронического алкоголизма, наркомании и токсикомании на 100 тыс. населения России составил 107,6. В структуре заболеваемости 95,9% приходится на алкоголизм. Обращает внимание значительное превышение во многих случаях числа состоящих на учете лиц с умственной отсталостью (в 2-2,5 раза) в сельской местности по сравнению с городской. Наиболее неблагополучна картина с психическим здоровьем населения в Центральном, Волго-Вятском, Центрально-Черноземном районах, а также в Западно- и Восточно-Сибирском регионах. В последние годы имеет место рост неврозов.

Болезни органов дыхания. В структуре заболеваемости органов дыхания преобладают острые формы, которые являются одной из основных причин утраты трудоспособности и экономических потерь государства. Из хронических заболеваний органов дыхания наиболее значимы хронический бронхит и эмфизема, фарингиты, болезни миндалин и аденоидов, пневмонии, бронхиальная астма, аллергические риниты.

Болезни органов пищеварения. Имеет место рост уровня патологии органов пищеварения, в частности, такого тяжелого ее проявления как язвенная болезнь желудка и 12-перстной кишки.

Эндокринопатии. Для населения России актуальна проблема сахарного диабета, который характеризуется высокой инвалидизацией и летальностью. Положение больных в настоящее время ухудшилось в связи с проблемами обеспечения диетическими продуктами и лекарствами. Превентивные меры в области эндокринологии должны быть направлены на выявление пацентов с патологической толерантностью к глюкозе, которые входят в группу риска сахарного диабета, а также скрининг новорожденных на врожденное увеличение щитовидной железы. Также большой проблемой являются эндемические и неэндемические заболевания щитовидной железы. Более 50% населенных территорий России, включающих регионы интенсивного промышленного и сельскохозяйственного производства, эндемичны по зобу (в частности, Башкирия, Татарста, Урал). Особенно наблагоприятная ситуация наблюдается на территориях, где имеет место радиационное воздействие после аварии на Чернобыльской АЭС - в первую очередь западные районы Брянской области.

Б. ВЕДУЩАЯ ПАТОЛОГИЯ В ОПРЕДЕЛЕННЫХ ГРУППАХ

Дети. Важнейшем показателм не только здоровья детей, но и социального благополучия общества яляется младенческая смертность. В 1992 году показатель младенческой смертности составил 18,0 на 1000 родившихся. Это самый высокий показатель среди экономических развитых стран мира. При этом можно выделить территории со стабильно пониженной (относительно других) младенчесокй смертностью и со стабильно высоким ее уровнем. Первые находятся в Европейской части России, вторые представляют в основном национальные образования, а также огромные территории Сибири и Дальнего Востока. Регионильные различия достаточно велики и колеблются от 15,6 в Северо-Западном районе до 20,0 в Северо-Кавказском и до 20,8 в Восточно-Сибирском районах. В Чеченской и Ингушской республиках данный показатель достиг величины 30,7. Среди причин младенческой смертности ведущими практически во всех экономических районах являютя состояния, возникающие в перинатальном периоде (асфикция, родовые травмы, недоношенность). На них в целом приходится 44,5%. Второе место занимают врожденные пороки развития - 21,4%, однако высоким (25,8%) остается удельный вес "экзогенных", устранимых причин - болезней органов дыхания, инфекционных и паразитарных болезней и т.д.

Высок уровень заболеваемости новорожденных: 20,3 новорожденных родились больными или заболели сразу. Среди новорожденных маловесные дети (менее 2500 г.) составляют 7%; доля преждевременных родов - 3,9%. К моменту выписки из родильного дома только 48,3% новорожденных являются практически здоровыми, 43,9% входят в группу риска развития хронических заболеваний и 7,8% имеет серьезную перинатальную патологию.

По данным обследования детей первого года жизни 40-60% имеют рахит, гипотрофию, диатез, 10% имеют анемию.

В структуре общей заболеваемости детей первое место занимают болезни органов дыхания, второе - болезни нервной системы и органов чувств. Происходит увеличение доли детей с отклонениями а физическом развитии, в частности, страдающих ожирением в раннем возрасте и дефицитом массы тела в старших школьных возрастах. Уже в дошкольном возрасте 15 - 20% детей имеют те или иные хронические заболевания, в школьном - 30%. Среди выпускников 45% имеют различные хронические заболевания и ограничения в выборе профессии по состоянию здоровья. Детская инвалидность составила 3,28 на 1000 детского населения. 25% тяжелых нарушений приходится на умственные нарушения.

Женщины. Серьезную проблему представляют нарушения репродуктивного здоровья женщин. Те или иные гинекологические заболевания выявляются у 10-12% девочек и девочек-подростков, у 40-60% женщин детородного возраста. 10-15% из числа состоящих в браке страдают бесплодием. Негативное влияние на здоровье женщин репродуктивного возраста оказывает широкое распространение абортов. Осложнения абортов служат одной из основных причин материнской смертности. Нормальное течение беременности и родов в последние годы наблюдается только у 20% матерей. Более чем у трети беременных выявляется экстрагенительная патология, более чем 60% - акушерская. 21,6% беременных страдают анемией. Развитие беременности на фоне хранической патологии нередко сопровождается осложнениями: токсикозами, угрозами прерывания беременности, аномалией родовой деятельности. Показатель материнской смертности в 1992 г. составил 50.8 (на 100 тыс. родившихся живыми).

Мужчины. По ожидаемой продолжительности жизни у мужчин Россия занимает последнее место в Европе. Мужчины живут в среднем на 11,7 лет меньше чем женщины. Снижение ожидаемой продолжительности жизни очень тесно коррелирует со смертностью от несчастных случаев, отравлений и травм. В рабочих возрастах имеет место сверхсмертность от этого класса причин, особенно в возрасте 20-44 года. Характерно, что на протяжении последних десяти лет колебания показателей смертности мужчин от несчастных случаев и травм происходии параллельно с ростом и снижением потребления алкоголя. В последнее время отмечается увеличение злоупотребления спиртными напитками. Так, среди подростков г. Москвы только 20,8% не употребляют алкоголь. На начало 1993 года под наблюдением лечебных учреждений состояло 2,5 млн. больных алкоголизмом и алкогольным психозом. Географически в России отмечается устойчивое увеличение алкоголизма в направлении с юга на север.

Пожилые. В России более 60% пожилых людей имеют те или иные хронические заболевания. По данным обследований среди населения 60-69 лет у 40% мужчин и у 60% женщин имеет место артериальная гипертония, у каждого четвертого мужчины и каждой пятой женщины - избыточная масса тела, 10% мужчин и 25% женщин имеют гиперхолистеринемию. Среди лиц старше 60 лет доля хронических болезней с выраженным снижением функциональных возможностей организма составляет более 30%. Наибольшее значение имеет ишемическая болезнь сердца, хронические неспецифицеские зоболевания легких и пневмония.

РАЗДЕЛ III
СОВРЕМЕННАЯ РОССИЙСКАЯ СИСТЕМА ЗДРАВООХРАНЕНИЯ

А. ОБЗОР

Реформа системы здравоохранения России началась уже в середине 80-х годов, но во многом она была ошибочна и непостоянна, поэтому систему, в целом, она не изменила. Подобный избирательный подход не мог решить многочисленные проблемы здравоохранения, которые возникли с развитием рыночных тенденций. В здравоохранении ситуация, по-прежнему, очень сложна, особенно из-за высокого уровня общей и детской смертности, снижения уровня рождаемости и снижения продолжительности жизни до 67,9 лет.

Общий спад экономики повлек за собой снижение общего количества врачей с 47,3 до 45,0 на каждые 10 000 человек. Также ухудшилась ситуация со снабжением лекарственными препаратами. Производство их уменьшилось на 13%, закупки импортных лекарств уменьшились на 12%, а закупки отечественных - на 18%. Спрос на лекарства удовлетворен приблизительно на 60-70%, но это неполная информация. Цены на некоторые лекарства растут значительно быстрее, чем уровень инфляции. Эти тенденции характерны для большинства регионов России.

Во многих секторах, помимо здравоохранения, современное состояние медицины усугубило общий кризис. Эти проблемы, несмотря на их глубину, являются всего лишь симтомами неблагополучия общества. Будущее российского здравоохранения, в значительной степени, зависит от общих негативных тенденций развития жизненного уровня населения, состояния здоровья, и, даже, - от успеха рыночных реформ и степени их социальной ориентации.

Увеличившаяся доля платных услуг в здравоохранении не соответствует низкому уровню доходов населения. Уровень доходов приблизительно 30% населения ниже официального минимума, а уровень доходов 15 миллионов человек составляет половину от него.

Сложная ситуация в здравоохраненинии России порождена слабостью и нестабильностью российской финансовой системы. В 1993 году бюджетный дефицит составил 11 триллионов рублей и увеличился почти в 11 раз (инфляция выросла в 10 раз). Некоторые независимые эксперты утверждают, что действительный дефицит бюджета составил 22-24 триллиона рублей (15% от ВНП). Результатом этого явилось резкое сокращение бюджетного финансирования социальной сферы, в целом, включая здравоохранение. В

действительности, здравоохранение финансируется по остаточному принципу. В 1993 году только 1,4% (в 1992 году - 1,7%) всех федеральных бюджетных затрат было предназначено на здравоохранение, а на практике было выделено всего 67% от этой суммы. Для сравнения, в 1985 году в СССР бюджетные ассигнования на здравоохранения составляли 4,6%, а в 1969 году - 6,6%.

Тем не менее, финансирование здравоохранение не так плохо, как может показаться. В Курской области, например, в 1993 году здравоохранение продолжало действовать как единая государственная система. В условиях экономической нестабильности функционирование этой единой системы было возможно благодаря профессионализму медицинских работников и развитию новых рыночных методов работы медицинских учреждений. Более того, областные бюджетные расходы на здравоохранение от всех расходов составили 6,9% в 1988 году, 7,8% - в 1991 году, 12,5% - в 1992 году и 17,1% - в 1993. Медицинским учреждениям также разрешили предоставлять платные услуги, что составило 0,9% от всех средств.

Введение рыночных методов, безусловно, ведет к децентрализации управления здравоохранением, многие управленческие функции были переданы в местные органы. Финансирование здравоохранения, в основном, останется заботой региональных властей, так как львиная доля доходов от налогов остается на местах. Система обязательного медицинского страхования также основана на том, что большинство фондов существуют на региональном уровне, возможно поддерживая те региональные изменения в здравоохранении, которые существовали раньше. Федеральный фонд ОМС смягчит различия, но вряд ли устранит их совсем. Децентрализация системы финансирования переложила тяжесть ответственности за принятие решений на регионы. Это позитивный фактор, так как это увеличивает ответственность за здоровье местного населения и предоставляет больше свободы и независимости в принятии практических решений, например - в привлечении местных финансов для нужд местного здравоохранения.

Изменения в системе российского здравоохранения набирают силу. Однако, эти процессы (переход от бесплатной медицины к полностью приватизированной), как правило, не систематизированы и не скоординированы. Идет процесс проведения рыночных реформ в российском здравоохранении. С одной стороны, явно видны положительные результаты, так как система здравоохранения приближается по уровню к рыночным требованиям: уменьшается число коек, повышается эффективность использования больничных коек, на местном уровне реорганизуется система использования кадров, растет объем и ассортимент услуг медицинских учреждений. С другой стороны, финансовое положение медицинских

учреждений нестабильно, доля платных медицинских услуг растет несмотря на неспособность большинства населения заплатить за эти услуги и, уровень больничной смертности вырос с 1,1% до 1,4%.

Система обязательного медицинского страховыания может сыграть важную роль в смягчении влияния трудных финансовых условий. В настоящее время начали действовать определенное количество организаций и программ медицинского страхования (фонды обязательного медицинского страхования, компании медицинского страхования), хотя внедрение этих программ ведется медленно и нерегулярно. Несмотря на все недостатки и противоречия система обязательного медицинского страхования заслуживает поддержки, потому что она является первой попыткой скоординировать развитие экономики с нуждами здравоохранения. В то же время, отсутствие организованной системы медицинского страхования приводит к отсутствию надежных данных по распределению финансовых средств в рамках системы.

Б. ИМЕЮЩИЕСЯ РЕСУРСЫ

Отмеченное ранее снижение показателей здоровья напрямую связано с отсутствием адекватных ресурсов в медицине. Эта часть содержит сведения об имеющихся ресурсах в России и об ухудшении ситуации по четырем позициям: (а) ресурсы организаций; (б) человеческие ресурсы; (в) технологичесике ресурсы; и (г) финансовые ресурсы.

Ресурсы организаций. Количество больниц и поликлиник в России и их мощность слегка уменьшились за последние три года. В настоящее время на 10 000 человек приходится 130 больничных коек, в 1991 году это количество сотавляло 135 коек, по сравнению с 90 койками на 10000 человек на Западе. Количество поликлиник уменьшилось с 20 900 до 20 600, но и это количество больше количества медицинских учреждений первичной помощи на тысячу жителей большинства западных стран. (См. Таблицу 2).[1] Больницы и поликлиники находятся по контролем государства. Также существуют поликлиники и больницы, находящиеся в ведении промышленных предприятий, эти медицинские учреждения составляют 10% от общего количества. Частные поликлиники и больницы редки. Частная практика чаще принята среди отдельных специалистов, например среди гинекологов или стоматологов.

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[1] Таблицы, выкладки и цифры собраны в Приложении III.

Физическое состояние российских лечебных учреждений плохое. Имеется немного недавних данных об их состоянии, но согласно опросу, проведенному в 1989 году, 85% требовали какого-либо ремонта. Многие не соответствуют свнитарно-гигиеническим требованиям, и 45% больниц не имеют ванных комнат и душевых. (См. Таблицы 3 и 4). То есть проблема состоит не в наличии больничных коек и первичной помощи, а в неудовлетворительном качестве имеющихся устаревших зданий и оборудования. Неэффективно располагаются отделения (нет соответствия между зданиями и отделениями больницы, узкие коридоры, нет лифтов и т.д.), палаты переполнены (6-12 человек в полате, иногда и мужчины и женщины размещаются вместе). Серьезные нарушения санитарно-гигиенических норм существуют даже в лучших медицинских учреждениях (например, использование асбестовых материалов в столовых и зданиях, в целом, отсутствие туалетов, ванных комнат и мусорных урн). Очень несовершенны системы обогрева и вентиляции, из-за чего некоторые помещения перегреты, а другие холодные и сырые.

Более новые медицинские учреждения имеют в некотором смысле лучшие помещения, особенно с точки зрения размещения отделений. Однако, строительство новых зданий было сокращено в начале 90-х годов и почти прекратилось в 1993 году из-за сокращения правительственного финансирования капитального строительства (См. Таблицу 5).

Человеческие ресурсы. Эта часть посвящена ресурсам непосредственно медицинских работников, т.е. врачей, медсестер, других медицинских работников, работающих в больницах и поликлиниках. Количество врачей на 10 000 жителей варьируется от 77,8 в Москве до 23,8 в Чечено-Ингушской автономной республике, средний показатель по России составляет 45 (См. Таблицу 6). Это число значительно превышает показатель на Западе; в Великобритании на 10 000 жителей приходится 14 врачей; в Германии - 30. Количество врачей в России остается неизменным в последние три года. Количество среднего медицинского персонала (включая медицинских сестер и других медицинских работников со специальным образованием) варьируется от 150,8 на 10 000 жителей в Мурманской области до 87,7 в Калужской области, средний показатель по стране составляет 113,6.

Относительный "переизбыток" врачей вызван тем, что они вынуждены выполнять многие обязанности, которые на Западе выполняет обычно медсестра: рентген, основная диагностика, мониторинг. Это, в свою очередь, уменьшает роль медсестры; многие медсестры занимаются тем, чем занимается на Западе младший медицинский персонал - собирает данные. Сочетание таких факторов, как низкая зарплата, долгие смены и неквалифицированная работа, привели к нехватке медицинских сестер,

Некоторые федеральные специализированные центры оснащены лучше по сравнению с другими медицинскими учреждениями и имеют более высокий технологический уровень, так происходит в Кардиологическом центре и Онкологическом центре в Москве. Кроме того, существуют ведомственные больницы и поликлиники, принадлежащие промышленным предприятиям и министерствам, которые были оснащены лучше, чем обычные лечебные учреждения Министерства здравоохранения. Однако, сейчас это уже не так, так как предприятия сократили социальные затраты. Например, больницы и поликлиники Министерства транспорта за последние два года не закупали никакого оборудования.

Последний опрос по поводу медицинского оборудования, проведенный в 1989 году, показал резкую нехватку основного оборудования, такого как рентгеновские аппараты и автоматические счетчики форменных элементов крови. Почти по всем лечебным категориям оборудование неадекватно, особенно нехватка оборудования ощущается в лечении кардиологических, сосудистых, ортопедических и почечных заболеваний. Даже относительно хорошо оснащенные московские больницы иногда не имеют необходимого оборудования. Например, больница # 5 на 200 коек использует ручной счетчик форменных элементов крови и имеет лишь два рентгеновских аппарата.

Нехватка оборудования настолько велика, что не позволяет проводить даже простейшее лечение, не говоря о специальных современных методах лечения. Например, нехватка диагностического оборудования приводит к очень низкому уровню ранней диагностики заболеваний. Поэтому большинство пациентов не получают помощи, или получают менее эффективную и более дорогостоящую помощь на поздних стадиях развития заболевания.

Система снабжения оборудованием практически не изменилась со времен плановой экономики и основана на прямом бюджетном финансировании. Руководители больниц и поликлиник должны сделать заявку на оборудование в местные руководящие органы здравоохранения. Замена старого и сломанного оборудования может занять несколько лет. Ассигнования производятся по возможности, а не с учетом обслуживаемых пациентов. Органы здравоохранения имеют большие полномочия, что ведет к злоупотреблениям и бюрократическому фаворитизму.

Нехватка бюджетных средств и неэффективность закупочной процедуры являются постоянным раздражителем для медицинских работников. Врачи часто копят свои собственные деньги, чтобы купить какое-то оборудование. Хотя таких случаев немного, но это уже может послужить сигналом того, что

официальная система не способна обеспечить лечебные учреждения даже основным оборудованием.

Поставка фармпрепаратов составляет 60-70% от необходимого количества. В некоторых случаях недопоставки составляют 80-90%. Средняя обеспеченность граждан фармпрепаратами составляет в денежном выражении 10$ на человека по ценам производителей, в то же время на Западе этот показатель составляет 125-250$ на человека. Частично этот дефицит можно объяснить развалом системы поставок из бывших советских республик и стран Восточной Европы, и этот вакуум в поставках не был заполнен растущими объемами поставок западных и азиатских фармпрепаратов. Более того, большинство врачей не знакомы с медикаментами, производимыми на Западе и имеют весьма ограниченный доступ к публикациям по этому вопросу. Неэффективность системы поставки лекарств приводит к дефициту и высоким ценам на лекарства. Россия не имеет адекватной производственной базы для производства жизненно важных лекарств в соответствующих объемах. В 1992 году работало 91 предприятие по производству фармацевтических субстанций, готовых форм и медицинского оборудования (См. Таблицу 8). Производство не смогло удовлетворить даже 40% потребностей по 6 из 8 основных лекарственных категорий (См. Таблицу 9).

Существует несколько объяснений неадекватности фармацевтических предприятий. Первое, заводы устарели. За последние 15 лет не было построено ни одного фармацевтического предприятия (кроме Акрихина, построенного совместно с "Бристол Майерс Сквибб"). Некоторые заводы были построены еще в начале нынешнего века. Эти заводы не только неэффективны, но даже опасны для потребителей, покупающих их несоответствующую требованиям и часто грязную продукцию, и для граждан, живущих поблизости от этих заводов и страдающих от загрязнений окружающей среды.

Второе, у российских производителей нет опыта в производстве многих фармпрепаратов. В условиях прошлой системы советские производители концентрировали свое внимание и усилия на производстве субстанций, готовые же формы производились в Восточной Европе. Даже сегодня импорт из Восточной Европы покрывает 40% рынка. Тридцать процентов жизненно важных лекарств никогда не производились в России.

Третье, ассортимент продукции устарел и слишком сложен. В терапевтической категории основные российские лекарства часто на одно-два поколения отстают от лидирующих западных лекарств. Зачастую западные компании не хотят выдавать новые лицензии как по

экономическим мотивам, так и по причинам контроля качества. Некоторые российские компании производят 150-200 видов продукции, создавая сложность, которая приводит к повышению цен и риска отравлений.

И наконец, организационные структуры неэффективны. Количество косвенных и непосредственных работников предприятий слишком велико. В то же время, отделы маркетинга и продаж находятся в зачаточном состоянии и неэффективны. Дистрибьюторские сети не развиты, что является шагом назад по сравнению со старой централизованной системой.

Существующая российская оптовая фармацевтическая система также неэффективна и потребует значительных изменений. Оптовая надбавка (10-25%) и их соотношение к розничной надбавке являются серьезными показателями проблемы эффективности. Деятельность оптовых организаций характеризуется тем, что на складах хранится малое количество лекарств, высокими административными затратами и низким уровнем услуг. Существующая система состоит приблизительно из 100 оптовых организаций со 130 складами. В Таблице 10 российский сектор оптовой фармацевтической торговли сравнивается с аналогичным сектором в ряде стран Западной и Восточной Европы.

Средний объем продаж меньше, чем в Западной Европе, что является отражением более низких цен на лекарства и, что важно, отсутствия торговли близкими товарами, как-то: косметикой, хозяйственными товарами, периодическими изданиями и т.д. Однако, количество аптек, обслуживаемых каждым аптечным складом, очень велико, и превышает лишь подобный показатель Германии и Великобритании, которые имеют высокоэффективные, полностью автоматизированные склады со сложными информационными системами. Чтобы улучшить обслуживание аптек (более частые поставки, широкий ассортимент), количество складов необходимо увеличить, особенно приняв во внимание возможный рост количества аптек.

Отделения "Фармации" являются монополистами в регионах, хотя на рынках Москвы, Санкт-Петербурга и некоторых других главных городов появились новые частные оптовые торговые организации. В других странах относительно небольшое количество общенациональных оптовых компаний интенсивно конкурируют друг с другом по всей стране. Эти общенациональные оптовые компании также предоставляют эффективные услуги предприятиям-производителям фармпрепаратов, которым не приходится работать с более, чем 100 региональными оптовыми организациями, как это происходит сегодня в России. Разница в структурах показана в Таблице 11.

Аптеки в России, хотя и не очень многочисленны (16 000, или 1 на 9 200 жителей) имеют ограниченные объемы продаж (обычно от 150$ до 170 000$ ежегодного оборота против 500 000-600 000$ в западных странах). В связи с небольшим числом аптек на столь большое количество жителей число это, вероятно, удвоится в ближайшие несколько лет. (См. Таблицу 12).

Финансирование. В этой части рассматриваются источники финансирования здравоохранения и основные статьи расходов, а также основные механизмы накопления и ассигнования средств. Общий кризис в области организационных, человеческих и технических ресурсов усугубляется, потому что финансовая система здравоохранения не имеет достаточных средств на нормальное функционирование здравоохранения, не говоря об улучшении. Здравоохранение в России всегда финансировалось по остаточному принципу, на него выделялось 2-3% валового национального продукта, тогда как в европейских странах этот показатель составляет приблизительно 8%. Даже с учетом низких зарплат средний уровень затрат в здравоохранении на душу населения очень низок. В последнее время бюджетные ассигнования на здравоохранение уменьшились весьма значительно.

Система здравоохранения сталкивается с рядом проблем:

- постоянное недофинансирование;
- финансирование на основе мощностей, что побуждает больницы иметь больше коек;
- финансировать занятость медиков, а не медицинские услуги;
- отсутствие основных навыков финансового управления среди администраторов;
- отсутствие информационной технологии;
- высокий уровень инфляции и недоразвитые рынки капиталов, что мешает развитию страховых фондов.

Финансирование здравоохранения претерпело три значительных изменения за последние несколько лет: (а) заметное снижение реальных затрат; (б) введение обязательного медицинского страхования (ОМС); и (в) децентрализация системы финансирования. Существующая система финансирования представляет собой смешанную систему бюджетного и страхового финансирования, при которой фонды обязательного медицинского страхования должны покрывать непосредственные расходы (оплата труда, медикаменты, питание в больницах) на лечение работающих больных. Федеральный и региональный бюджеты покрывают все остальные расходы. Правительственные бюджнтные ассигнования покрывают в

настоящее время более половины всех расходов на здравоохранение, но процент финансирования ОМС растет.

После периода ежегодного увеличения на 6-8% бюджетное финансирование здравоохранения дало сбой в 1992 году. Номинально правительственные затраты на медицину увеличились с 37 миллиардов рублей в 1991 году до 341 миллиарда рублей в 1992 году, но розничные цены увеличились в 26 раз, цены производителей увеличились в 34 раза. Таким образом, реальные затраты уменьшились на 95 % (Таблица 13, рис.1). Эта ситуация была слегка смягчена субсидиями предприятиям и министерствам, которые, в свою очередь, смогли финансировать свои медицинские учреждения. Общая сумма этих субсидий неизвестна, но вряд ли она превышает 10% всех затрат.

Больницы были самыми крупными объектами финансирования в здравоохранении, получив в 1991 году 57% от всех субсидий; на Западе больницы получают 44 % (См. Таблицу 14). Только 3% фондов уходит на общественное здравоохранение, при том, что российское здравоохранение ориентировано на лечение в больнице. Действительные общие затраты составили 3600 миллиарда рублей.

В 1992 году 80% бюджета здравоохранения контролировались местными органами, при том, что доля заработной платы и выплат социального страхования была достаточно велика и составила 60-63 (См. Таблицу 15). Спланированный на 1993 год бюджет составлял 1 407,9 миллиарда рублей:

- Зарплаты - 58%
- Питание - 9%
- Фармацевтические препараты - 8%
- Предметы по уходу за больными - 1%
- Ремонт и эксплуатация, транспорт, и т.д. - 15%
- Выплаты в ОМС - 9%

В 1993 году фонды ОМС собрали 1 100 миллиардов рублей, что составило 16,4% от запланированных 6 700 миллиардов рублей. В 1994 году фонды ОМС надеются собрать 27-28 триллионов рублей. По утверждениям Министерства здравоохранения системе необходимо 36 триллионов рублей, и Министерство предлагает увеличить налог на промышленные предприятия до 6,7%. Информация по поводу средств, аккумулированных региональными фондами ОМС, ограничена, но по некоторым сведениям территориальные фонды ОМС собрали лишь 35-40% возможных средств. Однако, в 1993 году в Москве фонд ОМС собрал 75% возможных средств, т.е. 92 миллиарда рублей и распределил их следующим образом:

- 54 миллиарда - на создание необходимого резерва;
- 19 миллиардов - на увеличение заработной платы медицинских работников в Москве;
- 18 миллиардов - на пополнение рабочих капиталов аптек после поднятия оптовых цен;
- 1 миллиард - расходы самого Фонда.

Значительные средства были истрачены при старых методах ассигнований.

Объемы и ассигнования на здравоохранение из региональных бюджетов проиллюстрированы в интервью в Твери и в Пермской области (См. Схемы VI и VII в Приложении III). Доля заработной платы была уменьшена на 26%, больше средств было истрачено на оборудование, ремонт и эксплуатацию, на предметы обихода (до 40%) в отличие от запланированных федеральных расходов. Резкое уменьшение реального финансирования здравоохранения повлекло замораживание практически всех капитальных затарат. Участие местных органов здравоохранения в управлении финансами различно. Например, Облздрав Новосибирской области наложил руку на финансирование, и ни одна закупка или распределение не может быть произведено без его участия. Однако, в Твери администрации больниц решают большинство вопросов самостоятельно в рамках ассигнованных средств.

Персональные оплаты составляют 8-12% всех затрат на здравоохранение, в основном - для закупок фармпрепаратов и оптики, только 16 % приходится на оплату медицинских услуг (См. Таблицы 16 и 17). Однако, эти цифры не означают непосредственных оплат наличными от пациентов врачам и медсестрам, которые по некоторым данным составляли в 1991 году, по крайней мере, сумму, в восемь раз превышающую заявленные персональные затраты. "Дополнительная оплата наличными" является в настоящее время основным источником дохода врачей.

Российская система здравоохранения не имеет соответствующих ресурсов для предоставления требуемых услуг, особенно финансовых и технологических ресурсов и качественных больничных условий. Менее остро стоит вопрос с людскими ресурсами, но крайне необходимо наладить систему обучения, обеспечить медработникам лучшие условия труда и большие зарплаты. Финансирование постепенно меняется по западному типу. Механизм ОМС не собирает столько средств сколько предполагалось, уровень варьируется в зависимости от региона и требует изменений. По-прежнему доминирует бюджетное финансирование, 60-70% поступает через традиционные каналы.

Нехватка правительственных средств должна покрываться за счет частных средств.

В целом, схема покрытия затрат не предусматривает учет эффективности и профилактику. Пациенты не могут выбирать врача, и медицинские работники получают оплату в соответствии с количеством выполненных процедур. Недостатки больничной практики - долгое пребывание в больнице, постоянная "полная загруженность", необходимость дополнительных оплат для получения дополнительных удобств или процедур. Частное финансирование не обеспечивает фондов для капитальных затрат, так как врачи не имеют никаких побудительных мотивов вкладывать деньги в государственное лечебное учреждение. Таким образом, современная система страдает от недостаточного общественного финансирования, при этом она не может привлечь частные средства.

В. СРАВНЕНИЕ С СИСТЕМАМИ ЗДРАВООХРАНЕНИЯ ДРУГИХ СТРАН

Этот раздел содержит сведения о принципах организации и механизмах финансирования систем здравоохранения пяти стран Европы. Здесь описываются: (i) голландская и немецкая система "Фондов больных"; (ii) британская и шведская системы, для которых характерно прямое государственное финансирование посредством целеноправленного налогообложения; (iii) система США, сочетающая частное и общественное финансирование.

ГОЛЛАНДИЯ

Философия системы здравоохранения. Медицинские услуги , в основе которых в большой степени лежит частная инициатива, часто бывают благотворительными. Исторически сложилось, что больничная система организована под эгидой конфессий (католической или протестанской) или политических партий (социалистов или либералов). Несмотря на объединения и совместные предприятия различных организаций, большинство из них остаются благотворительными и некоммерческими, находятся во владении и под руководством частных, местных, независимых советов.

Филантропия была постепенно вытеснена общественным финансированием и правительственными нормами. Ключевыми шагами в данном направлении стали Исключительный Акт о Медицинских Расходах 1967 года (AWBZ) и Акт о Медицинском Страховании. Первоначально AWBZ предусматривал долгосрочное и дорогостоящее медицинское обслуживание. К 1992 году в соответствии с ним покрывалось 45% всех затрат на здравоохранение.

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Скорее всего он распространит свое влияние шире, став основной схемой для медицинского страхования всего населения. В соответствии с Актом о Медицинском Страховании сейчас финансируются основные медицинские и больничные услуги для 60% населения.

Главной характеристикой голландской системы является то, что все население имеет медицинскую страховку; 66% населения имеют страховку "Фондов больных" (общественное страхование), 33% имеют частную страховку. Сегодня правительство несет общую ответственность за данную политику, и система характеризуется смешанным общественно-частным финансированием. Взносы за некоторые медицинские услуги основаны на способности платить, а доступ к жизненно важным медицинским услугам основан на определении необходимости. Большинство врачей ведут частную практику. Большие затраты на медицину привели к попытке контролировать стоимость услуг, но результат пока не известен.

Финансирование. Затраты на медицину, составляющие 8,1%, по европейским стандартам высоки (См. Таблицу 18). Исторически сложилось, что все затраты на медицину определялись потребностями пациентов (которые неограниченны) и определенными стимулами для медицинских работников предоставлять лечение. В настоящее время затраты все больше зависят от политических переговоров, направленных на сбалансирование бюджета по принципу удовлетворения потребностей как пациентов, так и медицинских работников. Существует постоянное давление с целью ограничить доходы врачей и капитальные расходы на больницы.

Увеличение финансирование через AWBZ происходит благодаря реформам, направленным на финансирование через один канал. В настоящее время правительство финансирует приблизительно 11% затрат на здравоохранение через предоставление средств AWBZ и оплату здравоохранения для государственных служащих (6% населения) (См. Таблицу 19).

Финансирование голландской системы здравоохранения происходит следующим образом: (1) 45%: через AWBZ все население получает обязательную медицинскую страховку на серьезные заболевания или длительную неработоспособность; средства поступают из подоходного налога, который платят работающие граждане, и ассигнований центрального правительства; (2) 24%: в соответствии с Актом о Медицинском Страховании (только для тех, кто в 1990 году заработал менее 23 500$) оплачиваются затраты на основные медицинские услуги, краткосрочное пребывание в больнице и помощь стоматолога. Средства поступают из подоходного налога, который платят работающие граждане и предприятия, и равных взносов; (3) частные страховые фонды, в которые поступают индивидуальные страховые

взносы: покрывают расходы на предпринимателей и тех, кто не подпадает под Акт о Медицинском Страховании, это 32% населения; (4) индивидуальные выплаты, которые могут быть сделаны в форме доплаты за услуги; (5) государственные служащие - 6% населения.

Результаты здравоохранения. Стандарты здравоохранения в Голландии считаются высокими. Пациенты имеют доступ к широкому набору услуг и возможность выбора медицинского специалиста. Опросы выявили высокий уровень удовлетворения системой здравоохранения, второй после Канады. Меры здравоохранения указывают на благоприятные условия. Продолжительность жизни мужчин и женщин является одной из самых высоких в европейских странах, очень низки уровни младенческой смертности и смертности от несчастных случаев. (См. Таблицу 20).

Реформирование системы. В настоящее время голландская система подвергается значительному реформированию. Три основные направления реформы следующие: (1) один пакет основных услуг для всех граждан и возможность для клиента выбрать страхователя и условия страхования; (2) создание больших стимулов для эффективности медицинских услуг, так как страхователи заключают договор непосредственно с медицинскими работниками; (3) переход от государственного регулирования к рыночной конкуренции. Как "Фонды больных", так и частные страховые фонды конкурируют для привлечения клиентов и получают из центрального фонда застрахованные от риска капиталовложения.

Механизм финансирования будет упрощен. 85% финансирования будет производится из центрального фонда, в который поступают средства от целевого подоходного налога, остальное платится в выбранную страховую организацию в форме установленной ставки (размер выплаты будет вопросом не индивидуального риска, а политики и страхования).

ГЕРМАНИЯ

Философия системы здравоохранения. Немецкая система входит в то, что называется "социальная рыночная экономика" которая составляет базу для социальной и экономической политики Германии - самоуправление, социальное партнерство и социальная солидарность. Самоуправление означает, что потребители медицинских услуг и медицинские работники должны действовать как самоуправляемые частные организации с наименьшим вмешательством правительственных организаций. Социальное партнерство означает, что и работники и работодатели должны разделять бремя финансирования здравоохранения. Социальная солидарность означает,

что более сильные, с экономической и финансовой точки зрения, граждане должны поддерживать более слабых, чтобы обеспечить равенство.

Финансирование немецкого здравоохранения характеризуется наличием самоуправляемых страховых фондов. За это столетие количество застрахованных граждан поднялось от приблизительно 20% до 90%. Предоставляемые права, основанные на общественном сознании, соответствуют международным стандартам и гарантируются всем, методы компенсации, большей частью, основаны на принципе оплаты за услуги. Очередей на медицинские услуги нет.

Система здравоохранения покрывает все, кроме долгосрочной или постоянной помощи, и основана на обязательном медицинском страховании. Эта, в большой степени, децентрализованная схема использует "Фонды больных", организованные на местном и национальном уровне, а также на уровне компаний, которые оплачивают большой ассортимент услуг (исключая долгосрочную медицинскую помощь). "Фонды больных" следуют принципу оплаты по диагностическим группам, и они имеют обязательства обеспечивать услугами или медицинской продукцией, но не оплачивать пациентов. Существует несколько видов фондов: некоторые организованы на основе географических регионов и компаний; другие - на основе различных профессиональных групп. Большинство населения автоматически застраховывается самостоятельно или через работодателей, хотя выбор страховых фондов ограничен. Работающее население обычно обращается в "Фонды больных" недалеко от места работы. Фирмы с более 1 000 работников могут открыть свой собственный фонд на основе компании, если это не повредит работе местного фонда.

В начале 70-х годов затраты на здравоохранение росли быстро в процентном отношении к валовому национальному продукту. В связи с экономическим спадом конца 70-х годов правительство предприняло несколько реформ. Акт о Здравоохранении 1989 года пошел дальше, увеличив размеры доплат за пребывание в больнице и за некоторые лекарства, введя выборочные проверки работы врачей и отменив контракты с неэкономичными больницами. Акт о Реформировании Структуры Здравоохранения 1993 года предусматривает сочетание радикальных организационных реформ и строгих мер по сдерживанию затрат во многих областях. Например, для ряда услуг рырос уровень доплаты; врачи должны планировать бюджет на лекарства и на свои услуги; существующее сейчас полное финансирование больниц заменяется финансированием по пролеченным случаям. В результате, правительство планировало сэкономить в 1993 году 10,1 миллиарда немецких марок, что составляет более 3 % затрат на здравоохранение.

Финансирование. В 1990 году Германия истратила 8,1% ВНП на нужды здравоохранения, что выше среднего показателя европейских стран. Только 14% финансирования здравоохранения поступает от правительства. Главная доля финансирования поступает из самоуправляемых "Фондов больных" (46%), из выплат предпринимателей (17%), пенсионных фондов (7%), из фондов страхования от несчастных случаев (3%), которые, в основном, работают через "Фонды больных". Другими источниками финансирования являются непосредственные взносы пациентов (7%) и выплаты по частному медицинскому страхованию (6%).

Фонды получают деньги за счет пропорционального подоходного налога, который в равной мере оплачивают и предприниматель, и наемный работник. В 1993 году средний размер взносов в Германский "Фонд больных" составлял 14% от фонда заработной платы. Данные фонды также действуют в качестве первых получателей пенсионных пособий и пособий по безработице. Еще одним источником поступлений в "Фонд больных" являются переводы из пенсионных фондов, местных пунктов регистрации безработных и благотворительных организаций. Граждане, имеющие большие доходы, могут заключить договор страхования с частной организацией по медицинскому страхованию. Приблизительно 90% населения застраховано в одном из фондов обязательного медицинского страхования, 8% застрахованы в организациях добровольного страхования, оставшиеся 2% являются государственными служащими, для кого медицинские услуги оплачиваются правительством. Менее 0,5% совсем не имеют медицинской страховки.

Результаты здравоохранения. Немецкая система, во многих отношениях, работает хорошо. Граждане Германии получают значительные блага. Существуют многочисленные лечебные учреждения, и они доступны по всей Западной Германии. Существуют некие листы ожидания там, где качество лечения считается высоким по международным стандартам. После объединения было решено ввести западную систему и в Восточной Германии. К 1991 году полная сеть местных фондов работала и в Восточной Германии.

ВЕЛИКОБРИТАНИЯ

Философия системы здравоохранения. Национальная служба здравоохранения была организована в 1948 году и оставалась неизменной сорок лет, что позволило сформировать некоторую мощную политическую и культурную поддержку. Она включает широкую поддержку концепции большого набора медицинских услуг, доступного для всех; мощную поддержку принципа равного качества услуг для всех; и политическое отвращение к "наживе на

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плохом здоровье". К концу 80-х годов явно проявились некоторые проблемы: неэффективность, длительное ожидание медицинской помощи, крайне бюрократизированная система, и неспособность справляться с растущими требованиями. В результате современных реформ право принятия решений переходит к местным управленческим органам и медицинским специалистам; разделяются системы покупки и предоставления услуг; реорганизуется структура первичной помощи, помощи при обострениях и помощи сообществу.

Финансирование. Пропорция ВНП, истраченного правительством на здравоохранение в 1992 году составила 5,7% по сравнению с 6,1% в 1990 году. По покупательной способности затраты на здравоохранения на душу напселения являются одними из самых низких в Европе, и в процентном отношении - также.

В финансировании и предоставлении медцинских услуг большая доля приходится на национальное общественное участие. Около 94% всех затрат на здравоохранения финансируется центральным правительством. На Национальную систему здравоохранения приходится 90% затрат Великобритании, из них 95% оплачивается при помощи общего налога и национального страхования. В результате Министерство финансов обладает огромной влиянием на общую сумму затрат; даже в соответствии с новыми реформами Министерство финансов сохраняет полный контроль над якобы финансово независимыми больницами трастов Национальной системы здравоохранения.

Преобладают общественные больницы, большинство врачей, медсестер и другого медицинского персонала являются наемными работниками или контракторами НСЗ. 6% медицинских услуг финансируются частным образом, через добровольное страхование или прямую оплату медицинских услуг. Доля населения с добровольным медицинским страхованием за последнее десятилетие выросла, достигнув 12% в 1991 году. Однако, это число ограничено, и используется для учета процедур, которым часто сопутствует длительное ожидание в НСЗ. Те, кто страхуется частным образом, не получают обратно денег из сумм национального страхования.

Частные лица вносят свой вклад через налоги или через оплату национальной страховки, вне зависимости от уровня пользования системой. Частные взносы обычно зависят от платежеспособности данного гражданина. НСЗ финансируется за счет общего налога (79%), взносов национального страхования (15%), оплат услуг (4%) и продажи земли (2%). Подоходный налог является источником медицинского страхования для большинства наемных работников. Уровень налогов значительно варьируется в

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зависимости от дохода, чем больше зарплата, тем больший процент зарплаты уходит в налог. Выплаты по национальному страхованию зависят от суммы подоходного налога. Эти выплаты составляют 9% от дохода в сумме от 2 808 фунтов до 21 060 фунтов. Предприниматели выплачивают от 4,6 до 10,4 процентов, в зависимости от дохода.

Результаты здравоохранения. Продолжительность жизни мужчин и женщин в Великобритании очень близка к среднему уровню в Европе. Детская смертность составляет 7,9 на 1000, что хуже среднего европейского показателя, составляющего 7,4 на 1000 детей.

Реформа системы. Для повышения эффективности системы правительство использует рыночные принципы.По Акту 1990 года изменения будут вестись в трех основных направлениях: (а) международный рынок для больничных услуг, включая разделение функций покупки и предоставления услуг; (б) организация трастов НСЗ и сообществ ; (в) бюджет для некоторых врачей общей практики для покупки больничных и других услуг от имени своих пациентов. Реформы развиваются быстро, 95% больниц должны приобрести статус трастов.

ШВЕЦИЯ

Философия системы здравоохранения. Швеция имеет общенациональную, но децентрализованную систему здравоохранения. Министерство здравоохранения и социальной заботы несет ответственность за законодательство по здравоохранению, тогда как применение и соблюдение этих законов находится в ведении местных советов. Фундаментальными целями являются "хорошее здоровье и здравоохранение на равных условиях для всего населения". В последние три десятилетия усилия были сконцентрированы на дальнейшей децентрализации. В Швеции имеются два вида местных органов управления - советы графств и муниципалитеты. Советы любого уровня имеют право регулировать налоги. В 1963 году ответственность за первичную помощь была переложена на советы графств; в 1967 году им была передана ответственность за психиатрические больницы. В 1982 году на советы графств была возложена ответственность за предоставление медицинских услуг и здоровье населения, и также они взяли на себя ответственность за оставшиеся университетские клиники. Советы обязаны обеспечивать здоровье жителям свои территорий, равный подход к хорошим медицинским услугам, планировать организацию здравоохранения. В 1991 году долгосрочная забота о престарелых была передана муниципалитетам.

Финансирование медицинских услуг (кроме долгосрочной заботы) является обязанностью советов графств, около 80% их затрат уходит на здравоохранение, частично финансируемое за счет местных налогов. Советы также получают материальную поддержку от государства и бюджетное финансирование на капитальные нужды от национального фонда социального страхования. Кроме того, национальная страховая система несет ответственность за оплату льгот наличными застрахованным гражданам.

Финансирование. Затраты на здравоохранение в 1990 году составили 8,7% от валового национального продукта. Это очень большая сумма. Только США, Канада и Франция среди всех стран - членов Организации экономического сотрудничества тратят больше. В 1988 году три уровня руководящих органов финансировали 89% затрат на здравоохранение: 59% - от налогов графств, 7% - от муниципальных налогов, 23% - от Национального Совета Социального Страхования и правительства, и только 11 % расходов оплачиваются из частных источников, в основном доплат пациентов за услуги.

Специальные программы, такие как исследования и подготовка врачей также финансируются правительством или советами графств. В 1990 году средний уровень налога советов графств составил 14,0%, это был пропорциональный налог на фонд заработной платы, без каких-либо дополнительных взносов. Средний муниципальный налог составляет 17,3%. Правительство ввело несколько налогов, самым важным из которых является прогрессивный подоходный налог . Он обеспечивает дополнительное финансирование, помимо финансирования советов графств и муниципалитетов. Верхняя планка всех прямых налогов в 1992 году была установлена на уровне 52%.

Результаты здравоохранения. Швеция достигла высокого уровня здравоохранения. Продолжительность жизни за последние 10 лет увеличилась на два года для обоих полов. Средняя продолжительность жизни мужчин составляет 74,8 года, что является третьим показателем для стран-членов Организации экономического сотрудничества и значительно выше среднего уровня в 72,6 года. Продолжительность жизни женщин занимает четвертое место и составляет 80,4 лет. Уровень младенческой смертности находится на третьем месте после Японии и Исландии.

Реформа системы. Реформы, проводимые в настоящее время, способствуют развитию конкуренции среди медицинских работников.

СОЕДИНЕННЫЕ ШТАТЫ АМЕРИКИ

Философия системы здравоохранения. США имеют многообразную, децентрализованную систему финансирования здравоохранения. Эта единственная из основных промышленных развитых стран, которая основывает свою систему на личной оплате и добровольном страховании, что составляет основу затрат на медицину. Это происходит из-за того, что с точки зрения культуры первенство отдается плюрализму, разнообразию, местным решениям и личной ответственности. Имеются два главных препятствия: растущие цены и большое количество людей, не имеющих страховки.

После Второй Мировой войны были начаты несколько программ, чтобы расширить и предоставление медицинских услуг, и спрос на них. Наиболее заметной из них была прогармма "Medicare" (Медицинская помощь), которая первоначально обеспечивала финансирование больниц на основе затрат и финансирование врачей на основе предоставленных услуг. Из фондов добровольного страхования оплачивались только фиксированные суммы на больничные услуги и минимальные расходы на услуги врачей; однако, введение Medicare изменило ситуацию, и страхователи перешли на новую систему финансирования. Возникли сильные стимулы для больниц и врачей увеличить объемы и стоимость услуг.

В результате, система здравоохранения значительно расширилась с 1960 года, затраты увеличилисьс 5 до 12% ВНП. Новые технологии и медицицинские исследования процветали, обеспечив прогрессивную, высококачественную и доступную помощь для застрахованных граждан. В 1983 году правительство перешло к системе выплат больницам фиксированных сумм за каждого пациента на основе единых расценок по диагностическим группам, предусмотренных Medicare. Так как правительство оплачивало более четверти больничных услуг, больницы имели стимул внести изменения в свою работу. Недавно правительство внесло изменения в систему оплаты работы врачей, позволив им установить расценки на основе предполагаемых затрат на каждый вид услуг, что также послужило стимулом увеличить объемы предоставляемой помощи. Частные страхователи также ответили на рост цен на медицинские услуги, переключившись на управляемую медицину.

Финансирование. Общие затраты на здравоохранение достигли 12% ВНП в 1990, как это показано в Таблице 1. США имеют самые большие затраты на здравоохранение в мире как в абсолютном, так и в относительном исчислении. В 1991 году правительство финансировало около 41% затрат на здравоохранение, разделенных между программой Medicare (18%), Medicaid (12%) и другими правительственными затратами на всех уровнях (11%).

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Частное страхование, оплачиваемое работодателями, охватывает 59% всего населения. Этот процент увеличивается приблизительно до 70%, если рассматривать только тех, кому меньше 65 лет. Около 4% охвачены программой, представляющей из себя сочетание Medicare и программы работодателей. 7% населения охвачены индивидуальным добровольным страхованием. Существуют различные неправительственные источники финансирования. Частное медицинское страхование, часто оплачиваемое работодателем, финансирует около 32% всех затрат США на здравоохранение. Частное страхование, не связанное с работодателями, регулируется штатами, при том, что каждый штат требует, чтобы страховка включала определенные льготы. При страховке через работодателя некоторые требования штата могут быть исключены. Личные выплаты составляют 23% финансирования, 4% идут из других частных источников, как-то благотворительные пожертвования.

Многие американские больницы являются некоммерческими учреждениями, что позволяет им получить множество льгот и освобождение от некоторых налогов. Некоммерческие больницы могут оплачивать покупки оборудования по низким процентным ставкам, получать льготы в налогообложении и оплачивать многие капитальные затраты по благоприятным ставкам. Некоммерческие больницы по сравнению с частными учреждениями экономят приблизительно 15-17%.

Приблизительно 13% американцев не имеют страховки. Medicaid охватывает приблизительно 6%, т.е. около половины этих людей. Все американцы 65 лет или старше подпадают под действие Medicare, охватывающей 9% населения. Военные и ветераны (2%) отдельно застраховываются правительством.

Результаты здравоохранения. Несмотря на значительные суммы, вкладываемые в здравоохранение, США имеют неравномерные результаты. Младенческая смертность значительно выше, а средняя продолжительность жизни мужчин и женщин значительно ниже, чем в среднем по Организации экономического содействия. Этому существуют различные объяснения. Безусловно, большой процент несчастных случаев и нападений является одной из причин. Кроме того, улучшения показателей здоровья зависят от средних слоев населения, а не от бедных, среди которых уровень смертности на 44-124% выше, чем среди пациентов, имеющих страховку.

Реформирование системы. В настоящее время обсуждается реформа национальной системы здравоохранения. Результат пока не известен.

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РАЗДЕЛ IV
ВОСПРИЯТИЕ ПРОФЕССИОНАЛЬНЫХ МЕДИКОВ И РОССИЙСКОГО НАСЕЛЕНИЯ, ПОЛЬЗУЮЩЕГОСЯ ИХ УСЛУГАМИ

А. ВСТУПЛЕНИЕ

Воззрение российского населения на здравоохранение перекликается с воззрением на государство и его политические институты в целом. Возникающаяся возможность выбора вызывает у людей затруднение; они обеспокоены тем, какая роль будет отведена им в новой системе здравоохранения, и тем, какова будет ее эффективность, качество, конкуренция и финансирование. Существующее положение в здравоохранении России рассматривается ими как бедственное, и настроения людей могут быть истолкованы исключительно как про-реформистские. В то же время, очевидно, что они довольны оказываемой им медицинской помощью и считают нынешние пробемы только временными.

Сопоставление с первого взгляда несообразных утверждений и мнений как медиков, так и населения дает понять, что в настроениях общественности требуется достичь хрупкое равновесие, с тем чтобы убедить ее в необходимости и пользе реформы. Это предполагает значительную роль общественного просвещения, призванного расчистить паутину невежества и проникнуть в темные углы иллюзий, которые пронизывают отношение общественности к реформе и приватизации.

Б. СУЩЕСТВУЮЩИЕ УСЛОВИЯ

Население, в целом, продолжает критически оценивать направление развития страны: 61% считает, что Россия находится "на неправильном пути". Кроме того, было замечено явное увеличение обеспокоенности по поводу политического руководства страной: 47% респондентов с высшим образованием считает это наиболее важной проблемой. Высокие цены, преступность и безработица также находятся в списке задач наиболее серьезных. Однако, российские граждане четко разделяют всеобщие проблемы, стоящие перед страной, от их личных проблем; так, население, пользующееся услугами здравоохранения, называет в качестве наиважнейшей проблемы политическое руководство, затем высокие цены (40%), безработицу (10%) и здравоохранение (10%) среди проблем, с которыми приходится иметь дело непосредственно им самим.

Большая часть российских граждан считает себя достаточно здоровыми, и лишь менее четверти (23%) говорит о своем здоровье как о плохом. Тем не менее 54% тех, кто старше 65 лет - а это значительная и увеличивающаяся

доля населения, указывают на плохое здоровье. Большая часть людей пользуется услугами поликлиник и придает им большое значение. Лишь 14% тех, кто пользовался бесплатным медицинским обслуживанием, давали медицинским работникам какие-либо подарки или деньги - явление, более распространенное в городах. В отношении качества лишь 8% оценивают получаемую медицинскую помощь как "плохую", а 90% полагают, что качество "отличное" или "хорошее".

Тем не менее, российские граждане чрезвычайно обеспокоены будущим здравоохранения и его качеством. Наибольшая обеспокоенность наблюдается на Дальнем Востоке и в больших городах, причем вопросы качества более волнуют людей хорошо образованных и людей с большими доходами. Почти 23% респондентов с высшим образованием отказалось от медицинского обслуживания по соображениям качества, а в группе респондентов с высокими доходами этот процент равен - 18%.

В. ВЗГЛЯДЫ НА СОСТОЯНИЕ ЗДРАВООХРАНЕНИЯ

Большинство российских граждан: как медики, так и потребители медицинских услуг, указывают, что они не удовлетворены существующим здравоохранением, причем 16% заявляет о своей "крайней неудовлетворенности". В этом вопросе мнения медиков и населения совпадают: так, 55% врачей, медсестер, работников администрации и фармацевтов выражают неудовлетворение существующим положением в здравоохранении. Однако, медики выглядят настроенными более критически, чем потребители медицинских услуг. 78% указывает, что система здравоохранения стала менее надежной, по сравнению с тем, какой она была 10 лет назад. Наиболее критически система здравоохранения оценивается на Дальнем Востоке (83%) и на юге России(59%). Врачи и представители администрации более критичны в своих оценках, чем такие категории медицинских работников, как младший медицинский персонал или фармацевты. Женщины-медики также настроены более критично, тогда как возраст не является определяющим фактором отношения к этому вопросу. Более 40% тех, кто не удовлетворен системой, винят "реформаторов в нынешнем правительстве".

Потребители медицинских услуг ссылаются на нехватку лекарств в качестве причины для недовольства (25%), причем этот показатель возрастает до 40% в сельских районах и среди руководства медицинских учреждений. Среди других приводимых причин - грубость врачей и общая некомпетентность. Устаревшее оборудование, длинные очереди в ожидании приема, недостаток специалистов и высокие расценки также вызывают озабоченность, но в

меньшей степени. Когда потребителей попросили назвать то, что тревожит их более всего, 39% указали на проблему "обеспечения больниц и поликлиник необходимым оборудования и лекарствами". Эта цифра возрастает до 49% в сельских районах. Другие же полагают, что первостепенной задачей правительства должна стать борьба с загрязнением окружающей стреды (16%). Однако, самой большой проблемой на индивидуальном уровне являются деньги: так, свыше 30% говорят, что наибольшую тревогу вызывает у них ситуация, когда "у правительства кончатся деньги для финансирования системы здравоохранения, и мы будет платить за лечение суммы, которые нам не по карману".

Действительно, 70% существенно обеспокоены тем, что "им, возможно, придется платить" за основные виды медицинской помощи, а подавляющее большинство (81%) выражает обеспокоенность тем, что "в случае серьезного заболевания одного из членов их семей" они не будут в состоянии оплатить лечение. Длинные очереди не представляют большой проблемы: так, 49% указывает, что им не приходится ждать приема врача вообще. Ожидание приема врача в медицинском учреждении не превышает 3 часов, причем 40% сказало, что их ожидание не превышало одного часа.

При опросе потребителей медицинских услуг выяснилось, что 78% чувствуют себя сейчас менее защищенными, чем 10 лет назад. Недоверие к системе здравоохранения выше в регионах, удаленных от Москвы: 87% в южной России, 83% на Дальнем Востоке и 79% на Урале и в Сибири. На вопрос о конкретных причинах их неудовлетворенности 39% назвало недостаточное финансирование. В качестве решения предлагалось следующее: 6% назвало перевод бесплатных медицинских услуг в разряд платных,5% предложило изменить всю систему в целом, и 1% поддержал приватизацию. Удивительно высокий процент - 45% медиков - не смогло назвать ни одного пути решения или же смягчения имеющихся проблем.

На вопрос о новом законе о медицинском страховании, лишь немногим половины - 57% - видело, читало или слышало о законе о медицинском страховании, принятом в прошлом году,тогда как уровень осведомленности медицинских работников на 30% выше (88%). В любом регионе страны осведомленность о законе превышает 50% и особенно высока на Дальнем Востоке (96% слышало о законе). Среди потребителей медицинских услуг наибольший интерес закон вызывает у респондентов с высшим образованием (75%), а среди тех, кто не имеет высшего образования, этот показатель снижается до 41%. Респонденты, попадающие в категорию недовольных, более открыты для реформ и проявляют больший интерес к закону: так, 61% респондентов этой группы слышало о законе. И наоборот, уровень осведомленности снижается до 47% среди тех, кто доволен положением и

отвергает реформу. Потребители также высказывались в пользу закона и его влияния на систему здравоохранения: так, 38% указало, что закон улучшит систему здравоохранения, которой они пользуются. Среди медиков этот показатель оказался равен 29%. Медики юга России и Дальнего Востока более позитивны в своих оценках, чем их коллеги в других регионах. Возраст является определяющим фактором в этом вопросе, причем положительные оценки более характерны для молодежи. Около 48% респондентов в возрасте до 45 лет полагают, что закон улучшит медицинское обслуживание.
Среди медицинских работников осведомленность о законе о медицинском страховании весьма значительная - 88%. Однако, медики поделены в их мнении относительно его воздействия: так, 33% медиков полагает, что закон приведет к ухудшению ситуации. Сельские медики придерживаются более оптимистичного взгляда на закон: так, 38% указывают, что закон приведет к улучшению ситуации. Респонденты-работники поликлиник настроены более критически, чем их коллеги в больницах и аптеках. Однако, определяющим фактором по этому вопросу является отношение к существующей системе. Среди тех, кто доволен ею, 34% полагает, что новый закон улучшит систему здравоохранения.

Потребителям медицинских услуг был также задан вопрос о кампаниях общественного просвещения. 66% российского населения сказало, что слышало о кампаниях агитации за здоровый образ жизни: так, среди молодежи процент слышавших равен 71%, причем он снижается до 58% среди тех, кому за 65. К сожалению, эти показатели не свидетельствуют о результативности. Менее 24% респондентов, знающих о кампаниях, "изменили свои привычки или же стали что-либо делать иначе". Кампании более результативны среди молодежи (30%), тогда как среди респондентов среднего возраста эта цифра снижается до 25%. В общем, люди хорошо знают о преимуществах профилактической медицины, и 71% согласен с мыслью, что "лучше предотвратить болезнь, посещая врача раз в год для осмотра, занимаясь зарядкой и правильно питаясь". Единственная группа, которая отвергает преимущества профилактики, - это пожилые люди.

Большая часть российского населения возражает против платности медицинских услуг, хотя примерно 40% населения предпочитают перемены, предлагаемые реформой, или же считают, что эти перемены будут не хуже существующей системы. 53% согласны с точкой зрения, по которой "люди не должны платить за медицинскую помощь, поскольку им не по карману элементарные медицинские услуги, хотя исключение должно быть сделано для случаев, когда создаются сверхкомфортные условия, такие как, индивидуальная палата или применяются очень дорогие методы лечения". 21% склонны согласиться с утверждением, что оплата медицинских услуг

создаст конкуренцию среди врачей и "заставит их улучшать качество услуг и при этом сохранять приемлемые расценки".

Как и можно было ожидать, пожилые люди более консервативны и более озабочены сохранением "бесплатного" медицинского обслуживания. Целых 67% тех, кому за 65 лет, полагают, что люди не должны никогда платить за медицинские услуги. В возрастной группе до 35 лет 40% поддерживают эту точку зрения, а 29% считают, что платность услуг - единственный способ, который усилит конкуренцию и улучшит качество.

Две трети респондентов без высшего образования (66%) придерживаются мнения, что здравоохранение должно оставаться бесплатным. Разницы в ответах городских и сельских респондентов не наблюдается. Население центральной и северной России выступает с большей поддержкой для бесплатной медицины (58%), чем на юге России (52%), Урале и в Сибири (47%) или дальневосточном регионе (51%). Тот же показатель среди женщин-респондентов на 6 пунктов выше, чем среди мужчин-респондентов.

Относительное большинство (46%) указывает, что они по-прежнему будут ходить в местную поликлинику, даже если вопрос оплаты не стоит как проблема, тогда как 22% сказали, что обратятся к частно-практикующему врачу. Желание лечиться у такого врача снижается на 20 пунктов при сравнении молодых респондентов (35%) и самых пожилых (16%). Хотя вопрос оплаты и не упоминался в ответах, фактор материального достатка является определяющим для этих ответов.

Со своей стороны 78% медиков утверждает, что существующая система здравоохранения не отвечает потребностям населения России, в то же время предлагаемые решения сводятся к старым рецептам, которые являются решениями собственных проблем медицинских работников. Почти 49% медиков говорят, что повышение зарплат является стимулом, который "должен быть доступен". Лишь 1% предлагает развивать частную инициативу, и 3% видят в переходе на самоуправление соответствующий стимул. Большая часть (69%) поддерживает концепцию конкуренции, "которая приведет к улучшению медицинской помощи при понижении затрат", что является сутью капитализма и свободной торговли.

Интересно, что 48% представителей администрации указывают, что у них есть полномочия изменять систему оплаты труда, причем этот показатель возрастает до 68% среди представителей администрации в центральной и северной России и 57% в городах.

Существующая финансовая система здравоохранения мало знакома даже медикам. По некоторым вопросам медики не способны даже приблизительно дать ответ о финансовой стороне функционирования медицинского учреждения. Менее 50% работников поликлиник способны ответить на вопрос о системе оплаты их труда, а для работников больниц этот показатель равен - 40%. Поскольку большинство не знает, как происходит оплата их труда, то не вызывает удивления затруднение при ответе на вопрос о том, какое воздействие окажет внедрение чистой системы страховой медицины на работу их учреждения.

Респонденты, занятые в частном секторе или в учреждениях, близких к частным, а также те, у которых есть дети, наиболее восприимчивы к идее, что оплата пациентами медицинской помощи является единственной возможностью для развития конкуренции и, отсюда, улучшения качества. Относительное большинство (46%) указывают, что они по-прежнему бы обращались в свою местную поликлинику, даже если бы фактора затрат не существовало, тогда как 22% говорят, что они бы обратились к частно-практикующему врачу. В каждом регионе местной поликлинике отдается предпочтение респондентов, причем отклонение от соответствующего обще-национального усредненного показателя никогда не превышает 2 пунктов.

Склонность пользоваться услугами частнопрактикующих врачей выше в дальневосточном регионе. Возраст и образовательный уровень значительно влияют на отношение респондентов к частнопрактикующим врачам, причем желание пользоваться их услугами уменьшается с 35% среди молодежи до 16% среди наиболее пожилых. Примечательно, что хотя затраты не назывались в качестве решающего фактора, уровень дохода по-прежнему остается таковым при принятии подобных решений. Желание обращаться к частнопрактикующему врачу на 17 пунктов выше в группе респондентов с высокими доходами, чем в группе респондентов с наиболее низкими доходами.

В географическом плане, сельские респонденты чаще приветствуют идею обращения ко врачу из некоммерческого учреждения, причем 63% высказало готовность обращаться в учреждение, входящее в систему медицинского траста. Но эти настроения ослабевают в городах, где соответствующий показатель снижается до 52%. Возраст продолжает иметь большое значение на ответы: так, готовность обращаться в медицинский траст уменьшается с возрастом. Однако, добавление слова "комерческая" к названию медицинского учреждения оказывает интересное воздействие на некоторые основные группы российского населения. Это добавление сильно умаляет достоинства учреждения в глазах клиентов в сельских районах (54%-9%), особенно на юге России. Тем не менее, эта капиталистическая добавка

несколько увеличивает число потенциальных клиентов для такого учреждения среди городского населения. В центральной и северной России желание обращаться в такие реформированные учреждения остается неизменным.

Добавление слова "коммерческий" производит особенно негативное впечатление на пожилых людей: так, после такого добавления процент поддерживающих такие учреждения в возрастной группе от 65 лет и старше падает на 10 пунктов. И наоборот, 67% респондентов с высшим образованием и 60% со средним специальным готовы обращаться к частно-практикующему врачу или в коммерческое медицинское учреждение.

Г. БУДУЩЕЕ И ВОЗМОЖНОСТИ ДЛЯ РЕФОРМЫ

При всех тревогах и опасениях, высказанных в адрес системы здравоохранения, несколько удивляет, что российские граждане остаются оптимистами, предсказывая будущее этой системы. Люди, в большинстве своем, думают, что система здравоохранения будет становиться лучше (32%), а не хуже (21%). Молодежь России более склонна давать оптимистичные прогнозы для системы здравоохранения. Оптимизм также имеет тенденцию возрастать вместе с доходом респондентов: так, среди респондентов с низкими доходами лишь 27% полагают, что здравоохранение улучшится. Все же, удивительно высокий процент респондентов (54%) согласен с утверждением: "Существующая система здравоохранения России, по сути своей, - хорошая система, и нынешние проблемы всего лишь временные." Эта точка зрения имеет большую поддержку в сельских районах (60%), чем в городах. В любом регионе страны этот показатель превышает 50%; эта точка зрения широко распространена, так что наблюдаются лишь небольшие отклонения в зависимости от пола, возраста или дохода.

Среди респондентов, довольных существующей системой и не желающих перемен, целых 74% согласны с идеей, что эти проблемы временные по своей сути. И наоборот, те, кто недовольны существующей системой и высказываются за реформы того или иного рода, не согласны с утверждением, что это - временные проблемы.

С точки зрения предпочтений, большинство российских граждан (55%) указало, что "обеспечение бесплатного медицинского обслуживания для населения России" имеет приоритет над "обеспечением наилучшего по качеству медицинского обслуживания для меня и моей семьи, даже если требуется сколько-то заплатить". В данном случае, возраст является определяющим фактором предпочтений: так, в возрастной группе 18-34 года отдают приоритет качеству 57%, а бесплатности 38%, тогда как в возрастной

группе от 65 лет и старше бесплатность выбрало 82%, а качество 13%. Более образованные респонденты также чаще отдавали предпочтение качеству, даже если это будет им чего-то стоить. Половина респондентов со средним специальным образованием и 55% респондентов с высшим образованием утверждают, что хорошее качество важнее бесплатности медицинских услуг; Это резко отличается от позиции респондентов с более низким образованием.

Медицинские работники поддерживают идею ограниченного государственного здравоохранения. С одной стороны, медики полагают, что государство должно финансировать психиатрические лечебницы и оплачивать лекарства по рецептам для детей. Широко распространена точка зрения, что профилактические осмотры также должны рассматриваться и покрываться государством как основные медицинские услуги, но, с другой стороны, аборты, планирование семьи/контрацептивы и подбор очков рассматриваются как обязанность пациента.

Доля российского населения, не удовлетворенного существующей системой здравоохранения и наиболее восприимчивого к реформе, составляет 46%.

Это респонденты:

- в Уральско-Сибирском регионе или в Дальневосточном регионе;
- в городах с населением, не превышающим 10 тыс. человек;
- возрастная группа 18-34 года;
- женщины до 45 лет;
- люди, имеющие детей;
- люди с высшим или средним специальным образованием;
- служащие;
- люди, полагающие, что проблемы здравоохранения коренятся в самой природе системы и не носят временного характера;
- люди, пользовавшиеся услугами платной и бесплатной медицины за последние два года.

Понятно, что все еще остаются опасения даже у людей, положительно воспринимающих реформу, но есть обнадеживающие признаки в данных, собранных в этой группе респондентов. Например, тогда как 60% респондентов из группы противников реформ, довольных нынешним положением, считают, что передача медицинских учреждений и фармацевтической промышленности в руки частных лиц и компаний сделает их в плане цен недоступными для большинства населения России, в группе недовольных системой с такой оценкой приватизации согласно менее половины (49%). В самом деле, 27% утверждают, что положение исправится.

Они в меньшей степени склонны ставить во главу угла принцип бесплатности здравоохранения, и скорее предпочитают согласиться с ограничениями медицинской помощи взамен на улучшение ее качества.

Потребителей медицинских услуг попросили выбрать между двумя противоположными точками зрения относительно приватизации, и более половины (52%) выбрали негативную точку зрения и согласились, что "передача системы здравоохранения в руки частных лиц и компаний приведет лишь к тому, что здравоохранение станет не по карману большей части российского населения, а предприниматели будут наживаться на несчастьях людей". Лишь 23% опрошенных отнеслось к приватизации положительно, считая, что переход российских больниц и фармацевтических заводов в руки частных лиц и компаний приведет к тому, что больницы будут более отзывчивы к потребностям пациентов, а недостатки, столь присущие государственной системе здравоохранения, будут преодолены путем развития конкуренции. В географическом плане, поддержка для развития частного сектора в здравоохранении более ощутима на Дальнем Востоке страны, чем в других регионах. Южный, Центральный и Северный регионы России выглядят наиболее консервативными.

Таким образом, необходимо соблюдать осторожность в выступлениях с целью расширить число сторонников процесса приватизации. Термин "приватизация" сам по себе вызывает негативные ассоциации у этой группы. Тогда как 39% в группе довольных утверждает, что "приватизация - это всегда плохо", в группе недовольных с этим утверждением согласно 47%.

И наконец, смешанные чувства вызывает вопрос проникновения на российский рынок западных фармацевтических компаний. Восприятие западных компаний как использующих ситуацию, чтобы эксплуатировать и делать деньги на несчатьях других людей, преобладает среди пожилых людей (49%), рабочих (47%), респондентов с низкими доходами (48%) и тех, кто полагает, что система здравоохранения будет деградировать (48%).

Среди потребителей медицинских услуг 45% не согласно с утверждением, что "западные компании, приходящие в Россию для продажи лекарств и медицинского оборудования, лишь эксплуатируют наших людей, и им следует запретить продавать на нашем рынке", тогда как 42% с этим согласно.

РАЗДЕЛ V
НОВЫЙ ПОДХОД К СИСТЕМЕ ЗДРАВООХРАНЕНИЯ

А. КЛЮЧЕВЫЕ ПРИНЦИПЫ НОВОГО ПОДХОДА

Ознакомившись с текущими проблемами здравоохранения в России, изучив нынешнюю систему и взгляды как медицинского персонала, так и пациентов, мы обратились к новому подходу. Необходимо быстро провести всю работу, чтобы избежать падения уровня качества при реформировании здравоохранения. Предлагаемые нами руководящие принципы следующие:

(а) осмысленный универсальный подход к
(б) развитой и эффективной системе здравоохранения через
(в) увеличение возможности выбора для потребителя и конкуренцию между медицинскими учреждениями, что приведет к
(г) улучшению здоровья и удовлетворению потребностей жителей России.

В целях обеспечения населения основным набором медицинских услуг существующие ресурсы России должны использоваться более эффективно. Несмотря на то, что увеличение доли ВНП, направляемой на здравоохранение является долгосрочной целью (также принимается во внимание необходимость снизить затраты) такое увеличение представляется маловероятным в короткий промежуток времени. На практике, тем не менее, в ближайшем будущем более эффективное использование ресурсов позволит изыскать дополнительные людские и материальные ресурсы. Кроме того, усилившееся сотрудничество между различными медицинскими учреждениями, как например - между больницами и поликлиника, также будет важным фактором.С другой стороны, сегодняшняя ситуация в здравоохранении, - например, длинные очереди для того, чтобы поставить диагноз или получить медицинское обслуживание, а также дефицит основных лекарств сохранится, и ситуация, возможно, ухудшится. Более продуктивное использование ресурсов означает более эффективное вовлечение в процесс хорошо обученных медиков, а также уделение большего внимания профилактической медицине, по сравнению с лечебной.Практически все обозреватели западных систем здравоохранения заключают, что профилактической медицине должно уделяться большее внимание. Это справедливо и по отношению к России. Так, результатом хорошей диеты станет более здоровая, продолжительная и продуктивная жизнь, что уменьшит нагрузку на работников здравоохранения. Особенно важно снизить уровень употребления спиртного, наркотиков и сигарет, изменяя общественное мнение посредством широкой просветительной

кампании. Своевременные осмотры у зубного врача предотвратят многие заболевания зубов и полости рта. Охрана окружающей среды должна быть усилеина, особенно - в промышленных регионах. Создание более безопасных рабочих мест с лучшим соблюдением санитарно-гигиенических правил позволит сократить затраты здравоохранения на лечение болезней, связанных с загрязнением воды, воздуха и несчастными случаями. Во всех случаях, потребуются разносторонние идеи в области общественного здравоохранения и усилия властей на всех уровнях.

Эффективная и рентабельная система здравоохранения на всех уровнях - профилактика, ранняя диагностика, лечение и реабилитация - также является необходимым условием для достижения цели проекта "Здоровая Россия 2000". Должны быть приложены усилия для избежания проблем, с которыми сталкиваются многие западные системы. Эти проблемы связаны с большими расходами на сложное оборудование и лечение, что в результате оборачивается тяжелыми финансовыми обязательствами и небольшим лечебным эффектом. Должны быть извлечены уроки из моральных издержек, созданных страховыми системами и налоговым законодательством, поощряющих чрезмерное использование услуг здравоохранения. Как уже было отмечено выше, из-за того, что в ближайшем будущем здравоохранение вряд ли получит большие объемы дополнительных ресурсов, эффективность и рентабельность здравоохранения должны стать центральной задачей реформы здравоохранения России.

Расширение возможности выбора для пациентов и конкуренция между медицинскими работниками будут импульсом для развития здравоохранения. Система поощрений медицинских работников будет направлена на повышение ответственности за здоровье пациентов, в свою очередь, они получат широкую возможность выбора, которой у них сейчас нет. Например, западные врачи осознают влияние конкуренции на их собственное отношение к нуждам пациентов. Практика платной медицины (как при оплате государством или страховыми компаниями, так и непосредственно пациентом) должна расширяться параллельно с государственной медициной. Врачи и другие медицинские работники в коммерческих лечебных учреждениях поймут, что их доходы зависят от эффективности их работы, а не от количества часов, ежедневно проводимых в поликлинике. Потребуется разработка норм оплаты не на основе продуктивности, а на основе качества работы, как в Екатеринбурге. Эти изменения потребуют общественного просвещения как потребителей медицинских услуг, так и медицинских работников, и затраты на эти кампании окупятся. Потребители медицинских услуг, которые понимают, что все эти изменения помогут им сохранять здоровье и что возникают новые возможности, станут теми потребителями, которые смогут влиять на систему.

Конечной целью является улучшение здоровья населения, что приведет к большей продолжительности жизни, более полному удовлетворению потребностей населения, повышению уровня благосостояния и социальных гарантий. Так как социальные трудности, связанные с реформированием других секторов экономики, обрушились на российский народ, что само уже может повлечь многие заболевания из-за психологических стрессов, чрезвычайно важно, чтобы реформа системы здравоохранения не стала дополнительной обузой. Это является общечеловеческим и политическим императивом. Здоровье граждан и их семей влияет на социальную стабильность и уверенность населения в завтрашнем дне. Необходимо сократить разницу в продолжительности жизни мужчин и женщин, а также снизить уровень младенческой и материнской смертности. Особую заботу следует проявить о детях, чтобы обеспечить здоровое будущее им, и удовлетворение и уверенность - их родителям и родственникам. Они должны получить необходимое образование по вопросам физиологии и морали. Что касается старшего возраста, необходимо добиваться снижения уровня заболеваемости по причинам обострений болезней и хронических заболеваний.

На этих принципах базируются основные направления проекта "Здоровая Россия 2000". Они должны встретить широкую поддержку российского населения в целом и, в частности, работников здравоохранения. Они подчеркивают важность усилий россиян, пытающихся добиться более высоких стандартов на основе имеющихся достижений.

Б. ПОЛИТИКА И СТРАТЕГИЯ, ВЫТЕКАЮЩИЕ ИЗ НОВЫХ ПРИНЦИПОВ

Численность росийского населения достаточно велика, чтобы создать медицину, конкурентноспособную во всем мире. Население хорошо образовано и включает сильное научное сообщество. В рамках системы, предлагающей соответствующие стимулы и четкие и определенные законные структуры, будущее российской системы здравоохранения может быть блестящим и удовлетворяющим нужды и желания российских граждан. Как уже отмечалось, реформы уже идут благодаря пилотным программам и местным инициативам, которые необходимо поддерживать и распространять по всей стране.

Достичь такого результата наиболее вероятно на основе приватизации и рыночно ориентированной политики, а также с учетом а) различных технологий и методов лечения; б) механизмов финансирования системы здравоохранения; в) сильно отличающихся местных условий по всей России. Более того, приватизационное законодательство должно создать

юридическую основу, которая а) защитит потребителей от частных монополий на всей уровнях; б) обеспечит финансовую жизнеспособность инвесторов, работающих в чрезвычайно нестабильной экономической обстановке.

В проекте "Здоровая Россия 2000" учитывается, что не все рекомендуемые реформы возможно провести сразу по всей России. Также принимается во внимание, что по ряду очевидных политических, экономических и социальных причин многие аспекты реформы здравоохранения должны проводиться в жизнь иначе, чем в других секторах экономики. Наконец, особое внимание должно уделяться подготовке к приватизации в тех регионах, где рекомендуется ее проведение. В регионах, где проведение приватизации не рекомендуется, правительство обязано улучшить систему управления и деятельность. Более того, национальные, региональные и местные правительственные структуры будут, по-прежнему, играть значительную роль в вопросах медицины и законодательства, затрагивающих такие действительно важные сферы здравоохранения, как защита наиболее уязвимых групп населения, например,- престарелых; в областях научных и медицинских исследований и образования; защиты прав интеллектуальной собственности и др. Однако даже в этой сфере стимулы и обязательства, характерные для рыночно ориентированной политики и стратегии, должны иметь возможно максимальное значение. Финансовый механизм, в котором правительство продолжит играть главную роль, будет предметом исследования в следующей части.

Частная практика врачей как индивидуальная, так и в составе товарищества или в приватизированной поликлинике должна поощряться. Пациенты должны иметь возможность выбора врачей и других медицинских работников, которые, в свою очередь, будут получать компенсацию в зависимости от количества и вида оказанных услуг. Большие поликлиники (200 или более сотрудников) могут быть разделены на мелкие, более специализированные частные учреждения (работающие на основе тех же принципов), включая организации, оказывающие административную и техническую поддержку поставщикам медицинских услуг. В Санкт-Петербурге одна из больших поликлиник разделилась на более мелкие функциональные подразделения, что принесло положительные результаты. Однако, эта модель, возможно, не может быть применена повсеместно, и медицинские работники должны сами выбирать.

Денационализация больниц и других основных медицинских учреждений может осуществляться несколькими способами. Во-первых, контроль над больницами должен быть формально передан местным, региональным и муниципальным органам власти. Процесс децентрализация уже идет de facto

и требует только юридического обоснования. Даже если больницы останутся в собственности государства, децентрализация контроля приблизит администрацию больниц к нуждам местного населения, обеспечит быстрое реагирование на реально существующую ситуацию. Пилотные проекты уже идут в больницах и поликлиниках, где сотрудники позитивно относятся к реформам, что повышает эффективность, улучшает управление финансами и делает ближе идею приватизации.

Во-вторых, необходимо поддерживать непосредственно приватизацию. Коммерческие больницы в западных странах предоставляют пациентам высококачественные медицинские услуги, также заботясь о благосостоянии и удобстве пациентов, как и государственные больницы. Используя на практике инвентаризационный контроль, электронную обработку данных и технологии, снижающие трудовые затраты, отдельные коммерческие больницы и сети больниц снизили стоимость медицинских услуг, при этом увеличив их объем. Например, коммерческие больницы стремятся сократить срок пребывания пациента в больнице, что положительно влияет на здоровье пациентов и экономически выгодно для больниц.

В-третьих, необходимо также всячески поддерживать создание частных некоммерческих или "благотворительных" больниц. Эти больницы могут находиться в собственности благотворительных организаций, профсоюзов, религиозных общин, научных организаций и т.д. Они могут быть освобождены от уплаты налогов, как это происходит во многих западных странах. В этой связи Россия может пойти по пути создания "Самоуправляемых больничных трастовых организаций" (СБТО) при денационализации системы государственных больниц, как это произошло в Великобритании, Израиле и Скандинавских странах совсем недавно. В результате этого процесса больницы приобрели статус "общественных трастов", являющихся некоммерческими организациями. Данный статус, безусловно, способствует выведению больниц из-под контроля государства.

Какая бы модель ни была выбрана в результате долгих споров - коммерческая больница, некоммерческая больница, или больницы, находящиеся под контролем национальных или местных правительственных организаций - она будет существовать за счет доходов от продажи услуг, а не за счет фиксированных бюджетных ассигнований правительства. Так как в этом случае поступления денег непосредственно зависит от пациентов, больницы должны сфокусировать свое внимание на качестве медицинских услуг и удовлетворении потребностей пациентов. В этом случае контроль над финансированием больниц переходит от бюрократов и больничных консультантов к тем, кто платит за эти медицинские услуги.

Больницы и поликлиники, остающиеся под контролем государства, должны заключить контракты с частным сектором на административные услуги. Это позволит увеличить эффективность и снизить цены, что пойдет на пользу потребителю. Во всем мире был достигнут успех в результате приватизации управления больницами, организации питания, услуг по стирке белья, поставке и эксплуатации оборудования, а также при приватизации специализированных медицинских услуг, как то - радиолога, анестезиолога и медицинской лаборатории. В тех больницах, которые не пойдут на заключение контрактов на управление, работающие в настоящее время управленцы должны получить дополнительное обучение по проблемам управления.

В области производства фармацевтических препаратов и медицинского оборудования сложились такие условия, что быстрая приватизация, возможности для иностранных инвестиций и торговых операций на стадиях производства, оптовой и розничной продажи создают условия для очень быстрого внедрения. Уже начинаются проекты, которые побудят американские фармацевтические компании увеличить объемы торговли и инвестиций в России, и законодательство находиться в процессе подготовки. Подобные же усилия могут быть предприняты и для того, чтобы привлечь в Россию и производителей фармацевтических препаратов. Иностранные инвестиции могут помочь и применению стандартов GMP. Приватизация и развитие конкуренции будут способствовать поступлению непрерывного потока фармацевтических препаратов и медицинского оборудования, лекарства будут более доступны, что снизит потребности в более интенсивных и дорогих формах медицинского вмешательства.

Производство фармацевтических препаратов и медицинского оборудования аналогично другим приватизируемым областям производства, поэтому уже проверенные варианты и методы могут быть применены и здесь. Например, в любом законодательном акте по приватизации важно предусмотреть защиту от возможности экспроприации приватизированных предприятий правительством, защиту от унизительного отношения к иностранным доходам и инвестициям, от ограничений в вывозе прибылей и в свободной продаже собственности внутри России. Очевидно, что законодательство должно также учесть особенности промышленности.

Особенно важным в данном случае является создание адекватной защиты права интеллектуальной собственности. Российский Закон об иностранных инвестициях гарантирует иностранным предприятиям, по крайней мере, такие же права на интеллектуальную собственность, какие гарантируются российским гражданам и предприятиям. Необходимо принять меры предосторожности, чтобы все это соответствовало международным

стандартам и практике, чтобы избежать нарушений, которые могут в значительной степени дезорганизовать международную торговлю и инвестиции. Более того, существующие надбавки к ценам производителей, оптовых и розничных продавцов распыляют средства, чего необходимо избежать.

Приватизация поможет создать успешно функционирующее, рентабельное фармацевтическое производство при изменении неадекватной производственной базы, устаревшего производственного оборудования, устаревшего ассортимента продукции, неэффективной организации труда и контроля за качеством. Однако, кроме приватизации необходимо провести другие изменения, чтобы создать подходящий климат для проведения программы "Здоровая Россия - 2000". Необходимо внедрить международно признанный ассортимент продукции и стандарты качества и как можно быстрее удалить ненужные барьеры к внедрению новых терапевтических препаратов. Российское правительство должно утвердить список жизненно важных препаратов, на основе списка, утвержденного Всемирной организацией здравоохранения, и этим списком необходимо руководствоваться при выпуске продукции на приватизированных предприятиях, чтобы удовлетворить нужды потребителей.

В области распределения и розничной торговли фармацевтическими препаратами и медицинским оборудованием, в России сейчас присутствует монопольный контроль на уровне оптовой торговли, неэффективные методы распределения и нерентабельная система розничной торговли. Тем не менее, многие сторонние наблюдатели уверены, что система распределения, возможно, единственное наиболее всеобъемлющее звено в будущей эффективной фармацевтической системе. Необходимо срочно начать кардинальные реформы. Правительство должно и в дальнейшем развивать конкуренцию и желание инвестировать средства в эту жизненно важную область, одним из требований для предоставления лицензии должно стать наличие полного списка необходимых терапевтических агентов, как упомянуто выше. Правительство также должно рассмотреть возможность приватизации сети географически разбросанных структур оптовой торговли, с целью создания национальных оптовых частных компаний. Наименьшее количество ограничений (например, свободное предоставление лицензий на оптовую торговлю) является способом создания конкурентноспособной и эффективной системы распределения. В любом случае, это произойдет достаточно быстро, особенно если иностранным оптовикам будет разрешено обращаться за лицензиями.

Приватизированные аптеки не должны иметь постоянный стимул продавать дорогие препараты, когда есть более дешевые аналоги. Финансирование на

основе единой согласованной системы расценок устранит этот стимул. В некоторых странах владеть аптеками могут лишь дипломированные фармацевты. Такое ограничение только помешает создать выгодную конкуренцию. Компании, владеющие целыми сетями аптек и снижающие цены благодаря большим оборотам, - это не выход из положения. Навыки частного предпринимательства - как в области оптовой торговли, так и розничной - в настоящее время полностью отсутствуют, будет необходима соответствующая подготовка и поддержка для овладения методами частного предпринимательства.

Эти общие направления развития и стратегии, которые вытекают непосредственно из принципов нового подхода к здравоохранению, пропитывают программу "Здоровая Россия - 2000". Они отражают надежды и чаяния российского народа, как выяснялось в результате наших опросов, и намечают направления будущего развития.

В. ФИНАНСИРОВАНИЕ ЗДРАВООХРАНЕНИЯ

Россия унаследовала систему, при которой Правительство финансировало ситему здравоохранения и управляло ею. В 1991-1992 году, последнем году, за который доступна информация, здравоохранение почти полностью финансировалось из федерального и местных бюджетов. Размеры этого финансирования определялись Министерством здравоохранения и местными здравоохранительными организациями и составляли 82% всех расходов на здравоохранение в 1991 году. К сожалению, в рамках старой системы на самом деле существовало 3 уровня с точки зрения качества. Для номенклатуры и некоторых других существовали эксклюзивные медицинские учреждения. Уровнем ниже стояла система здравоохранения для работников важных советских министерств и государственных предприятий. Остаток финансовых средств приходился на большую часть населения.

Однако, в 1993 году вступило в силу новое законодательство об обязательном медицинском страховании (ОМС), на базе которого стали возможны далеко идущие реформы в области финансирования системы здравоохранения. ОМС создает внебюджетный источник финансирования, а также механизм аккумулирования и распределения общественных средств, предназначенных для нужд медицины. Процесс введения системы ОМС медленный и нестабильный, отчасти потому, что остается множество нерешенных вопросов. В том числе: а) определение пакета основных медицинских услуг; б) определение формулы для расчета затрат на душу населения; в) определение правительственных субсидий на здравоохранение; г) разработка региональных уравнительных механизмов; и д) разработка методов оплаты за предоставление услуг. По-прежнему остается непонятной до конца роль

частного финансирования, что зависит от решения вопроса о приватизации. Доля частного финансирования неуклонно растет. Однако, здесь мы рассматриваем, в основном, проблемы общественного финансирования.

Своевременное решение этих проблем создаст финансовые механизмы и соответствующие стимулы для развития лучшей системы здравоохранения, равенства, эффективности, и удовлетворения нужд потребителей медицинских услуг. Если не решить эти проблемы своевременно, существует риск, что фонды ОМС будут растрачены впустую, не принеся реальных результатов и не использовав историческую возможность для реформирования российской системы здравоохранения. Необходимо начать с тех вопросов, решение которых потребует меньше времени, что станет основой для решения более сложных и долгосрочных проблем на основе собственного опыта России.

Главное структурное изменение в рамках ОМС заключается в создании независимых фондов обязательного медицинского страхования (ФОМС) на федеральном и территориальном уровнях для управления средствами, поступающими от налога на заработную плату, а также из федерального и территориального правительственных ассигнований. Фонды являются независимыми, некоммерческими финансово-кредитными учреждениями (таким образом, разделяя финансирование здравоохранения от действительного предоставления услуг), отвечающими за сбор основной части средств у работодателей и местных властей. Федеральный страховой фонд должен стремиться к равенству регионов, но в настоящее время для этого не существует четких направлений.

Организация и оплата медицинских услуг для потребителей должны производиться организациями двух видов, с которыми будут заключать контракты региональные фонды медицинского страхования (РФМС). Законодательство предусматривает существование страхователей (фонды, страховые компании и филиалы РФМС). Страхователи будут получать средства, исходя из числа застрахованных граждан. Закон разрешает общественным страхователям привлекать для работы медицинских работников из лечебных учреждений за дополнительную оплату, или использовать независимых медицинских работников, таким образом, они будут функционировать как организации здравоохранения или брокеры медицинских учреждений. До настоящего времени развитие страховых компаний происходило беспорядочно, с разнообразными вариациями по регионам. В Москве было приблизительно 20 страховых компаний, обладающих лицензией в рамках ОМС, которые формируют очень конкурентный рынок, и фонды ОМС на 100% рассредоточены у страхователей. В Архангельске, напротив, существует только одна страховая

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компания, обладающая лицензией, занимающая монопольную позицию.

Территориальные фонды ОМС будут регулировать здравоохранение от имени потребителей медицинских услуг там, где не созданы страховые компании или не развернули свою работу, что позволит привлечь общественность к управлению здравоохранением, но не обязательно к предоставлению медицинских услуг. Эта модель наиболее подходит для сельских и малонаселенных районов. В настоящее время фактически все средства из фондов ОМС направляются в конечном счете в больницы, а ограниченное число поликлиник может быть охвачено в начале 1995 года. В этой связи, однако, существует множество вариаций. Новгород и Барнаул, несмотря на нехватку фондов, начали с больниц и поликлиник одновременно. В Москве процесс начался с поликлиник, и в настоящее время 50% расходов поликлиник финансируются из фондов ОМС.

Согласно программам добровольного медицинского страхования, граждане и организации могут самостоятельно выбирать страховую компанию. До сих пор неясно, какова роль фондов ОМС, местных властей в области здравоохранения, страховых компаний в контроле затрат и качества предоставляемых медицинских услуг. Как и в других случаях, существуют значительные различия по регионам. В Твери, например, фонд ОМС - очень сильная и активная структура, в то время как в Новосибирске он практически отсутствует. Нет нужды говорить, что подобные различия затрудняют процесс управленческого планирования.

Подушный принцип финансирования, в отличие от прямого бюджетного финансирования, зависит от двух взаимосвязанных предпосылок: конкуренция среди медицинских учреждений, и выбор информированными потребителями. Подушный принцип финансирования основан на объединении риска и выплатах на основе "усредненных" показателей по однородным группам. Эти средние показатели не могут и не должны включать компенсации в случаях маловероятных ситуаций с высокими затратами, таких как эпидемии и природные бедствия. Это утверждение также верно для редких заболеваний, требующих дорогостоящего лечения. Предоставление услуг и тщательный контроль в таких ситуациях должны происходить через общие фонды или специальные резервы.

Предоставление медицинских услуг будет осуществляться на основе конкуренции, но это зависит от форм собственности медицинских учреждений. Итак, медицинская помощь могла бы предоставляться государственными учреждениями, частным сектором или врачебными кооперативами. Затраты организаций, предоставляющих медицинские услуги будут компенсироваться на основе предопределенных тарифов,

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установленных на основе обсуждений с местными административными органами здравоохранения, профессиональными ассоциациями и страховыми компаниями (на основе проведенных операций, количества вылеченных случаев или по подушному принципу).

Закон предлагает гражданам 3 варианта для выбора. Первый - обращаться в любую страховую компанию или фонд по желанию, минуя предприятие, где работает данный гражданин. Это позволит время от времени обращаться к другим страховым компаниям и фондам. Второй вариант - выбор организаций, предоставляющих медицинские услуги. Третий вариант - разрешить шире применять систему частных оплат за медицинские услуги.

Предприятия платят в страховые фонды 3,6% фонда заработной платы, из этих средств 0,2% направляется в федеральный фонд, а 3,4% поступает в территориальные фонды. Целевой налог на заработную плату выплачивается напрямую в региональные и федеральные фонды, а не страхователям; деньги от налога не предназначены для снижения поступлений из государственного бюджета. Все источники финансирования в каждой области будут объединены под эгидой вновь созданного РФМС, который будет финансироваться из общих средств, налога в фонд ОМС и уравнительных фондов (в случае их существования). Где возможно, РФМС будет платить страхователям, которые, в свою очередь, будут взаимодействовать с организациями, предоставляющими медицинские услуги.

Большая часть общественного финансирования здравоохранения, по оценкам 55%, будет производиться за счет поступлений из федерального и местных бюджетов, по крайней мере, в ближайший период времени. Вторая часть (30%) будет поступать из налоговых выплат предприятий и организаций (включая правительственные и бюджетные) в фонд ОМС. Частные расходы на здравоохранение и частные страховые фонды, скорее всего, возрастут, так как налоговые поступления и государственные бюджеты останутся рассредоточенными. Эти частные выплаты важны не только как источник дополнительных средств, но и как стимул для граждан к развитию некоторой финансовой ответственности за свое здоровье.

Не заменяя существующие системы, дополнительные фонды (в случае правильного управления) помогут российской системе здравоохранения достичь уровня 1991 года в использовании ресурсов, хотя все деньги, поступающие в федеральный фонд, не помогут выравнить положение в регионах.

С точки зрения затрат, необходимо предотвратить разницу в уровнях финансирования здравоохранения. Хотелось бы предотвратить снижение

уровня финансирования, которое может произойти в результате высоких темпов инфляции. Необходима стабильность в уровнях финансирования. Соответственно, периодически необходимо устанавливать реальные нормы финансирования, принимая во внимание состояние здоровья населения, медицинские технологии и состояние экономики.

В то время как местные руководящие органы должны передать средства в РФМС за работающих граждан, остается нерешенным механизм и уровень их ответственности и участия в страховании неработающего населения. Закон об обязательном медицинском страховании утверждает, что местные органы власти ответственны за равное медицинское обеспечение неработающих граждан. Это можно интерпретировать следующим образом: государство несет ответственность за медицинского обеспечение неработающих граждан на основе тех же принципов финансирования, применяемых по отношению к работающему населению, при котором уровень заработной платы и размер налога на заработную плату определят общий уровень общественного финансирования здравоохранения. Из-за колебаний излишков и дефицитов средств, однако, стабильность системы подвержена риску, хотя риски возможно смягчить с помощью создания резерва, который бы финансировался из излишков. Реальный уровень расходов на здравоохранение будет исчисляться на основе формулы определения затрат на душу населения. Таким образом, предопределяется бюджет, формируемый на основе общих поступлений, а не целевого налога, и любое превышение в налоге в фонд ОМС будет способствовать созданию резерва.

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РАЗДЕЛ VI
ВНЕДРЕНИЕ НОВОГО ПОДХОДА

А. НОВЫЕ ЗАКОНЫ И ПОСТАНОВЛЕНИЯ

Основа нового законодательства для децентрализации и приватизации здравоохранения России уже создана Законом о Приватизации, принятом 3 июля 1991 года, и поправками от 5 июля 1992 года, а также несколькими последующими законодательными актами парламента и указами президента. Сейчас необходимы, и по возможности - очень быстро, новые законы и постановления, отвечающие конкретным нуждам будущей системы здравоохранения. Более того, традиционная система здоровья и безопасности, созданная вокруг системы здравоохранения, должна поддерживаться и укрепляться.

Принамая во внимание трудности общественного финансирования, должны быть созданы и внедрены как можно скорее специфические законодательные и регулирующие режимы для частных страховых компаний (они до сих пор не существуют). Еще более важным для экономики в целом, и критическим для отдельных действующих программ по страхованию, является срочное создание жизнеспособных финансовых рынков.

Согласно Указу Президента # 2284 от 24 декабря 1993 года, для приватизации предназначены больницы, поликлиники, большая часть высших медицинских учебных заведений, предприятия-производители фармацевтической продукции и медицинского оборудования, почти все оптовые и розничные организации, торгующие медикаментами и медицинской техникой. Запрещена приватизация некоторых передовых медицинских учебных заведений, научно-исследовательских институтов, детских домов, и домов престарелых.

Для учреждений и предприятий, разрешенных к приватизации, общий процесс уже хорошо определен: (1) оценка приватизируемых активов для определения начальной продажной цены и уровня уставной капитализации (2) разработка приватизационных форм для составления оперативных планов приватизации; (3) процесс торгов и продажи для определения владельца приватизированного предприятия; (4) реальный перевод государственных и муниципальных предприятий в разряд акционерных предприятий.

Понадобятся специальные методики, разработанные для данной конкретной системы здравоохранения. Оценка поликлиники, например, может оказаться очень сложной, так как главным активом являются знания и уровень медработников, эта единица достаточно абстрактна и трудноизмерима. Точно

также, приватизационные фонды (там где служащие накопили достаточные средства для покупки акций) должны быть приспособлены к большому разнообразию участников здравоохранения. Приватизационный фонд предприятия-производителя фармпрепаратов может очень сильно отличаться от фонда больницы или поликлиники.Врачам частной практики могут понадобиться новые юридические формы, такие как "профессиональная корпорация", юридический смысл которой отличается от акционерной компании. Не должна быть упущена из виду выгодность создания товарищества, а также индивидуальной собственности например, для розничных торговцев фармпрепаратами и других.

Должны быть созданы юридические нормы и для учреждений, не подлежащих приватизации. Например, больницы должны принадлежать местным правительствам как "муниципальные корпорации", эта концепция в настоящее время еще не известна в России, она предусматривает сохранение государственной собственности вместе с деполитизацией и здоровой деловой практикой. Аналогичные формы ("привелигированные федеральные корпорации") также подойдут в случаях национальной собственности. Необходима законодательная база владения и управления учреждениями здравоохранения неправительственными организациями, также важно определить права и обязанности директоров и служащих таких предприятий.

В сущности, все исследователи современной системы Российского здравоохранения считают, что одной приватизации не будет достаточно. На самом деле, при отсутствии сопутствующих реформ, приватизация может провалиться и привести к огромным негативным политическим последствиям. Например, замена общественных монополий частными монополиями не будет являться прогрессом. Следовательно, государственные предприятия должны изменяться таким образом, чтобы впоследствии была конкуренция и отсутствовала монополия. Избежать создания региональных монополий можно, как было отмечено выше по отношению к оптовым поставщикам фармпрепаратов, путем группировки и реформирования существующих местных монополий таким образом, чтобы обеспечть создание национальных фирм-конкурентов.

Другой пример - розничная торговля фармпрепаратами. Законодательство должно обеспечить им возможность торговать не только фармацевтческими препаратами, таким образом увеличивая конкуренцию среди них. После окончания приватизации должны быть приняты жесткие меры, по типу антитрестовских законов, направленные против возможности удерживать монопольно-высокие цены, сговора при делении рынка и других неприемлемых приемов конкурентной борьбы. В конце концов рыночные

силы заработают, но на начальном этапе решающей задачей является недопущение монополизации в частном секторе, не вызывая при этом обратной экономической и политической реакции.

Ранее мы подчеркнули значение прав на интеллектуальную собственность, и предмет, связанный с ними, особенно для фармацевтов - это отмена нынешней неэффективной системы дотаций на фармацевтическую продукцию. Эта система поразила как целую фармацевтическую промышленность, так и структуру больниц и поликлиник. Несомненно, отмена дотаций приведет к значительным потрясениям, хотя осуществление этих мер после приватизации минимизирует их. На самом деле, существуют веские аргументы в пользу отмены дотаций и льгот уже до приватизации, что побудило бы всю систему тут же начать перестраиваться.

Не вызывает сомнений, что по ходу претворения в жизнь проекта "Здоровая Россия - 2000" будет возникать потребность в немедленном создании законодательной базы. Однако, нам не следует дожидаться, когда появятся все необходимые юридические документы. Законы и положения должны следовать за решениями, принимаемыми как часть политического курса, и никак не наоборот. Как только политический курс определен для каждой сферы в результате дебатов, следует немедленно приступить к программам незамедлительной подготовки соответствующих юридических законов и положений, оценке требуемых вложений и перемен, а также иностранного участия, если оно желательно.

Б. СИСТЕМА ФИНАНСИРОВАНИЯ

Обязанности правительства включают: определение политики, обеспечение конкуренции, финансовых исследований и подготовки. Еще раз следует подчеркнуть, что при необходимости принятия решений о роле частного сектора, мы рассчитываем на общественное финансирование, особенно ОМС. Тем не менее, наиболее желательным способом решения проблемы финансов, является создание многочисленных источников финансирования. Реальный уровень затрат на душу населения 1991 года, до того , как основные изменения затронули систему, должны быть приняты за первый ориентир на пути оздоровления и стабилизации.

Основная программа ОМС определяет объем и условия медицинского и фармацевтического обслуживания для всего населения России, включая минимальный объем услуг по 29 специальным направлениям. Территориальные программы должны развиваться на этой основе, их объем не может быть меньше объема федеральной программы. Данная программа включает (а) первичное медицинское обслуживание, включая неотложную

и профилактическую помощь; (б) стационарное обслуживание; и (в) обеспечение фармпрепаратами больниц. За лекарства, получаемые через поликлинику, население будет платить как правило из частных фондов или через систему страхования. Были сделаны следующие мероприятия: (а) предприятия будут платить за лечение последствий неблагоприятного производственного влияние и острых профессиональных заболеваний; (б) частные фонды и участники ОМС будут платить по установленному тарифу за необходимые медикаменты и средства по уходу за больными, предоставляемы больницами и поликлиниками; и (в) федеральные фонды будут платить за "дорогостоящее" обслуживание (например, трансплантацию органов и сердечно-сосудистую хирургию).

После принятия закона об обязательном медицинском страховании, в России были предприняты значительные усилия для определения основного набора услуг, что было параллельно усилиям, предпринимаемым ОЭС. Основной проблемой этих программ является отсутствие систематической оценки возможности с финансовой точки зрения. Российской реалией является определение критических ресурсов в короткий срок, что ставит под большой риск качество учреждений, заинтересованность медперсонала, качество обслуживание, а также возможность реформы системы. Не смотря на то, что эффективность обязательного медицинского страхования продолжает повышаться, масштабы этого процесса пока не ясны.

Существуют четыре возможные решения: (1) местный правительственный бюджет субсидирует деньги на финансирование неработающих; (2) местное правительство производит ассигнование на здравоохранение в объеме 1990 года (тот же процент местного ВНП), в дополнение к финансированию, получаемому после принятия закона о медицинском страховании; (3) местное правительство предоставляет дополнительные средства от налога на заработную плату, таким образом, чтобы эта сумма составляла долю здравоохранения, предоставляемую местной экономикой в 1990 году; (4) увеличение частных ассигнований. В Приложении III представлена детальная диаграмма о притоке финансов, а также возможности привести систему в равновесие.

Все решения являются экономическими и политическими проблемами. увеличение налога - даже незначительное - при сокращении (или стабильном, но небольшом) ВНП, ставит под угрозу другие секторы экономики. Более того, само экономическое положение может очень затруднить сбор адекватного налога на ОМС предприятиями и государством, даже если его ставка будет увеличена. Также будет сложно увеличить размер частных поступлений при нездоровой экономике. Перераспределение приоритетов при использовании налоговых средств с большим акцентом на

здравоохранение может быть сложным или даже невозможным на практике. Другой возможностью могло бы быть установление относительно высоких налогов на табак и алкоголь. Эта мера одновременно способствовала бы увеличению объема денежных средств (которые бы использовались на здравоохранение), а положительному изменеию образа жизни.

К сожалению, существует и пятое решение - продолжение снижения расходов на здравоохранение до полной стабилизации экономики, и после этого - увеличение финансирования. Увеличение количества безработных, например, не только ухудшит общее экономическое положение, но и сократит объем налоговых поступлений в ОМС, что поставит здравоохрание в еще более сложную ситуацию. Итог будет крайне нежелательный, но необходимо признать возможность такой ситуации.

Принимая во внимание нехватку средств, все заинтересованы в избежании чрезмерно большого количества инвестиций или недостаточно эффективного использования капитала, что стимулирует инфляцию в системе здравоохранения. Капитальные затраты на уровне первичного обслуживания вызывают меньшие опасения (инвестиции в этой области обычно не высоки) чем на более высоких уровнях системы обслуживания, где требуется большой объем инвестиций, особенно - на новые и дорогие технологии.

Таким образом, правительство склонно контролировать большие капиталовложения в систему здравоохранения. Такой контроль может осуществляться различными способами: от "подтверждения необходимости", как это делалось в Соединенных Штатах для частных инвестиций, до установления государственной монополии на такие инвестиции (как в Канаде и Швеции). Однако, из-за того, что поставщики медицинских услуг могут заменить дополнительные товары и услуги на указанные в регулирующих актах, не совсем ясно, какие общие затраты контролирует государство. Более того, рыночная мощность существующих больниц может быть увеличена в случае, если конкуренты не могут сделать капительных вложений. Нововведения также сократятся при снижении конкуренции. Если правильство останется единственным источником некоторого вида инвестиций, будет сложено порвать связь между общественным бюджетом и так называемыми "общественными больницами". Другой альтернативой является более эффективное использование существующих ресурсов, или перераспределение их . Ярким примером могло бы послужить расширение количества амбулаторных услуг за счет некоторых процедур, которые раньше осуществлялись в стационаре. В настоящее время стоимость койки составляет от 3000 до 11000 тысяч долларов в год и различается от региона к региону, а усилия по сокращению ненужных мощностей и перераспределению ресурсов на стационарное обслуживание практически не

осуществляется. Было бы необходимо сократить количество ненужных (или малоиспользуемых коек), а высвободившееся за счет этого пространство использовалось на более продуктивные цели. Периодический контроль за использованием ускорил бы этот процесс. Многие из опасений по поводу расхода финансов также актуальны в сфере финансирования медицинских исследований. Также существует большая неопределенность по некоторым вопросам, среди которых проблема финансирования играет не последнюю роль, а возможные долгосрочные и краткосрочные решения могут сильно отличаться.

В. ПОДГОТОВКА РАБОЧЕЙ СИЛЫ И ПОДДЕРЖАНИЕ КАЧЕСТВА УСЛУГ

Реформа здравоохранения потребует значительных изменений мышления и уровня подготовки в ряде категорий. Особое внимание уделяется следующим вопросам: навыки управления и деловые качества, медицинское образование, а также качество обслуживания. Непосредственно этот пример доказывает то, что документ "Здоровая Россия - 2000" - это динамическая, а не статическая модель.

Навыки управления. Общие навыки управления должны включать философию управления, организацию, принятие решений и делегацию полномочий. Информационные системы управления являются следующим важным компонентом, связанным с систематизацией различных моделей, обеспечением качества, фармацевтическим и инвентарным менеджментом, а также общим использование финансов. Финансовое управление особенно важно при стимулировании автономии учреждений, которая реально появляется на всех уровнях поставщиков медицинских услуг.

Финансирование здравоохранения включает такие концепции как риск, страхование и систему совместной оплаты. Различные поставщики должны иметь доступ к информации. Система медицинской информации должна включать общее использование финансов, планировние встереч, управление по виду заболевания и сбор данных. В широком смысле система маркетенга включает стимулирование здоровья и профилактику заболеваний. В сфере удовлетворения потребностей потребителей должно быть учтено доставление удовольствия потребителю, а также предоставление более высокого уровня услуг . Будет закочена доработка следующих вопросов: участие потребителя в планировании общественного обеспечения, страховых фондах, а также другие сопутствующие вопросы.

Образовательные программы по менеджменту для администрации и врачей должны немедленно начаться в следующих трех областях:

- Развитие ядра образовательной программы по менеджменту. Замечательным образцом является программа мененджмента, разработанная Московской Медицинской Академией, она должна быть принята в других основных образовательных центрах. Образование не должно ограничиваться только врачами, должны быть также привлечены экономисты, юристы, а также другие потенциальные управляющие.

- Назрела критическая необходимость обмена информацией между различными регионами России, а также создания российского журнала по медицинскому менеджменту.

- Продолжение ознакомления и исследования международных нововведений, таких как усилия, предпринимаемые Американской Международной Организацией Здравоохранения в больницах России и Америки.

Образовательные программы должны включать очень широкий спектр различных возможностей. Фактические и потенциальные руководители должны пройти шести-двенадцатимесячные программы по общественному здравоохранению, управлению больницей, и планированию здоровья, в таких учреждениях как Московская Медицинская Академия или экстерном сдать экзамен на звание магистра общественного здравоохранения или управления. Могут также быть организованы и краткосрочные курсы по управлению. Другие специальные области образования включают программы по семейному планированию и социальным исследованиям для предотвращения несчастных случаев, злоупотребления алкоголем и курением.

Должны быть разработаны индивидуальные программы и программы для небольших групп в связи с поощрением рыночных отношений и приватизации, которые должны включать вопросы от подсчета затрат, отношения потребителя и маркетинга до более сложных задач.

Медицинское образование. Создаются новые стандарты для медицинского высшего и последипломного образования. Но в условиях современной децентрализации в системе здравоохранения трудно сказать будут ли приняты в областях стандарты, навязанные сверху. Не подвергается сомнению необходимость изменения для обеспечения эффективного и гибкого удовлетворения реальных нужд здравоохранения.

Россияне проявили значительный интерес к концепции "семейной практики", которая может расширить сферу деятельности уже существующих врачей низшего уровня, "фельдшеров", а также увеличит их эффективность.

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Это также может привести к улучшению отношений между поставщиком и потребителем медицинских услуг, и более полному удовлетворению нужд пациента.

Учебная программа должна постоянно обновляться таким образом, чтобы устаревший материал заменялся более современным. Дополнения программы должны охватывать оценку качества, медицинскую экономию и уделение большего внимания превентивной медицине. Должны быть созданы условия, облегчающие обмен опытом с наибоее прогрессивными зарубежными институтами. Должна быть модернизирована система экзаменов, там, где это представляется целесообразным, некотрые вопросы должны быть расширены или пересмотрены, а также переведены в случае необходимости. Особое внимание должно уделяться компьютерной грамотности. Уровень доступности медицинской литературы очень различен по всей стране. Идея распространения медицинских русско- или англоязычных журналов или отдельных статей по факсу не потребует значительных затрат.

Особое внимание должно уделяться перераспределению обязанностей между врачом и медсестрой, а также переходу от доминирующей системы стационарного обслуживания к расширению амбулаторных услуг и профилактической медицине. Дополнительное расширение роли терапевта и педиатра приведет к повышению профессиональных стандартов. Усовершенствование существующей системы специального образования могло бы также привести к повышению качества обслуживания. Существующая система, которая больше похожа на профессиональные товарищества, братства, готовит специалистов очень различного уровня качества. Должна быть также изменена система подготовки и переаттестации специалистов, с тем, чтобы сделать ее более гибкой и отвечающей потребностям общества. В этой области потребуется сотрудничество с различными профессиональными группами России.

Должно поощряться увеличение существующего срока последипломного образования от 1-2 до 2-3 лет. Продолжение медицинского образование остается очень важным моментом, предусматривающим возможность специальной последипломной переподготовки в общей практике и узких специальностях. Последипломное образование должно быть расширено следующими дисциплинами: семейное планирование, превентивная медицина, а также привлечение технологий для постоянного повышения качества, медицинский менеджмент и участие потребителя.

Реформа образования среднего медицинского персонала дожна быть осуществлена на основе изменения роли медицинской сестры. Должно быть расширено образование медсестер в связи с предоставлением более важной

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роли, они должны получать более широкую подготовку в плане обследования пациента и его лечении. Услуги медсестер на дому станут новой сферой приложения этих навыков.

Качество медицинского обслуживания.
Качество медицинского обслуживания является показателем, определяющим эффективность реформ здравоохранения. Качество является больным вопросом для поставщиков медицинских услуг. Настоящая система направлена на выявление и наказание нарушителей, что часто осложняется укрывательством и фаворитизмом. Новая, более гибкая система с более высоким уровнем участия должна быть создана для отбора, оценки врачей, а также для соответствия уровня обслуживания местным нормам качества. Основные задачи следующие: 1) определение целесобразной системы повышения качества; 2) систематизация сбора информации и обмена данными; и 3) интеграция процесса в систему медицинского образования. Мы предлагаем следующее:

- Развитие практических параметров врачами под контролем Российской Академии Медицинских Наук. Каждая областная/городская страховая компания разработает независимую структуру для оценки качества, которая будет состоять из поставщиков, общественных деятелей, потребителей а также работодателей, для обеспечения контроля и эффективности работы каждого поставщика медицинских услуг.

- Создать группы постоянного повышения качества из поставщиков медицинских услуг. В их функции будет входить определение потребителей, описание процессов, выбор и создание приоритетов критериев выполнения и контроля, документировние и изменение.

Что касается больниц и поликлиник, уже осуществляется работа по обеспечению качества. Эти программы обычно иерархичны и автократичны, иногда чрезмерно детализированы, часто направлены на наказание. Возможность участия потребителя слишком мала. Для эффективной работы всей системы должны быть созданы основные направления и стандарты качества, они могут быть созданы на основе системы аккредитации больниц и поликлиник США.

В программе обеспечения качества больниц и поликлиник должна быть предусмотрена подготовка по вопросам менеджмента для руководителей. Должны быть созданы принципы контролирования и улучшения качества, основанные на принципах соглашения, а не автократического контроля. Должны быть также задействованы российские профессиональные

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организации, особенно организации главврачей, для определения рамок работы по обеспечению качества, а также для рассмотрения финансовых факторов и эффективности работы.

Должны быть также развиты механизмы вовлечения поставщиков и потребителей медицинских услуг в систему оценки качества. Одним из вариантов могло бы стать создание общественных советов, ассоциаций служащих, а также женских советов. Важным вопросом качества является соответствие обслуживания нуждам общества. Существуют ли вопросы качества, такие как проблемы окружающей среды и превентивная медицина, к которым адекватно обращается система здравоохранения. Доступно ли медицинское обслуживние для всего населения?
Дожна быть возможность для сбора и анализа демографических, эпидемиологических данных и информации об использовании. Должны быть также созданы местные комитеты из поставщиков, потребителей, представителей правительства и промышленности, которые смогут пересмотреть эти данные и принять решение о том, какое направление следует избрать здравоохранению для улучшеня здоровья населения. Общественные критерии должны определить этот наименьший возможный уровень качества.

Г. КАМПАНИИ ОБЩЕСТВЕННОГО ПРОСВЕЩЕНИЯ

Данные опроса показывают важность организации кампании общественного просвещения, с тем чтобы добиться поддержки со стороны медицинских работников и населения, пользующегося услугами медицинского обслуживания. Без подобной кампании провести в жизнь необходимые перемены будет сложно, не вызвав обеспокоенности людей за охрану их собственного здоровья и обеспокоенности по поводу роли правительства, призванного заботиться об этом. Тем не менее, правительство РФ не должно обязательно принимать как данное общественное мнение, существующее сейчас. Политические лидеры должны направлять этот процесс.

Цели. Общей направленностью кампании является активизация поддержки той части населения, которая наиболее заинтересована в переменах в системе здравоохранения. Эта часть населения состоит из тех категорий граждан, о которых шла речь ранее, а именно - молодежи, женщин моложе 45 лет, женщин с детьми, женщин из сельских районов, в том числе Урала и Сибири, тех, кто считают, что система порочна в корне, тех, кто имеет высшее образование и высокий доход, и тех, кто прибегает к услугам как платной, так и "бесплатной" медицины.

Как только будет мобилизована поддержка этой части населения, возникнет сильная база поддержки процессу реформ. Таким образом, в то время как 55% российского населения предпочитают идею "сохранить медицинское обеспечение бесплатным для всех российских граждан" идее "обеспечения должного качества медицинского обслуживания", даже если это означает оплату определенных затрат, база поддержки для идеи качества медицинского обслуживания, конкуренции и права выбора остается по-прежнему значительной. Даже по фундаментальному вопросу о всеобщеем здравоохранении, единого мнения не было: 33% населения высказались об отсутствии необходимости такового, а 60% заявили, что некоторые ограничения обеспечат более высокий уровень обслуживания.

Цель кампании общественного просвещения, таким образом, подразумевает следующее:

- увеличить ответственность граждан за свое здоровье;
- обеспечить поддержку реформе со стороны поставщиков и потребителей услуг;
- развивать новые структуры и использовать существующие структуры внутри российского здравоохранения для координации кампании с целью активизации общественной поддержки;
- добиться широкого освещения всех преимуществ, особенно связанных с приватизацией, реформы системы здравоохранения и поддержки для нее при помощи средств массовой информации;
- организовать обучение и содействие в вопросе организации медицинских ассоциаций и разработать механизм создания базы поддержки идее конкуренции, выбора и стимулов в здравоохранении;
- организовать кампанию общественной агитации посредством печатных материалов и средств массовой информации, разъяснения сущности реформы, убеждения в ее направленности на улучшение качества медицинских услуг и внедрение более эффективной рыночной модели управления;
- содействовать Госкомимуществу при организации обсуждения в масштабе страны на уровне правительства, Думы и общественности и вовлечь население, что увеличит шансы реформы на успех;
- обратить внимание на успехи, достигнутые в ходе выполнения пилотных программ, которые послужат образцами в будущем;
- проведение опросов общественности, фокусных групп и интервью для оценки изменений в общественной мнение по поводу реформы в здравоохранении.

Элементы программы. Программа общего информирования должна отражать внутренние политические реалии. Она должна считаться с существующим

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состоянием общественнного мнения относительно приватизации и новыми вопросами, которые будут подняты при реформировании системы здравоохранения. Программа должна способствовать росту кратковремменой и долговременной поддержки, которая придает импульс позитивным элементам всеобъемлющего освещения событий в области здравоохранения, и, кроме того, вводит и оформляет понятия выбора, конкуренции, эффективности и качества. Эта программа информирования будет существенно отличаться от традиционных программ, проводимых в средствах массовой информации. Она будет адресной, направленной на две основные категории населения: население, пользующееся услугами здравоохранения, и медицинские работники; особый акцент будет сделан на заручении поддержкой со стороны ведомств, организации ассоциаций, которые могли бы сыграть роль движущей силы в информировании о событиях в области здравоохранения в будущем.

Программа должна быть ориентирована на будущее, особое внимание уделять профилактической и превентивной медицине, мобилизовать различные пропагандистские группы медицинской общественности для создания поддержки предложенным направлениям:

- развеять опасения российских граждан относительно финансирования системы здравоохранения, ввести понятие "траста" в лексикон общественности, настроенной скептически в результате прошлой деятельности правительства, убедить общественность в том, что всеобъемлющий характер здравоохранения остается основополагающим принципом российского здравоохранения;
- добиться понимания в вопросах, затрагивающих интересы населения как потребителя медицинских услуг, таких как качество и выбор, а также убедить в том, что по ходу претворения реформы в жизнь преимущество, связанное с улучшением качества здравоохранения, отразится на российской семье, делая ее более продуктивной и счастливой.
- освещение аналогичных процессов, связанных со свободой выбора, в восточно-европейских странах и других странах для населения, вовлеченного в реформы;
- изучить учебные планы всех уровней обучения и привлечь профессиональных преподавателей, чтобы способствовать восприятию реформы в здравоохранении;
- рассмотреть возможность проведения мероприятий на местном уровне, таких как организации агитбригад, и использования руководств по информированию и агитированию, предназначенных для местных ассоциаций, поликлиник и пр.

- объяснить, почему рост конкуренции среди медицинских работников приведет к улучшению качества медицинских услуг и снижению расценок на эти услуги для тех, кто ими пользуется, и для правительства.
- проверить поддержку системам реформ, таким как поддержка страхования, основанная на "трастах здоровья"

В сущности, эта программа предполагает два взимо-усиливающих подхода. Программа, проводимая в масштабе страны, будет затрагивать общие темы поддержки процесса реформ, и представлять новые идеи как информацию для повышения заинтересованности. Это может иметь форму телевизионных программ, объявлений и рекламы в средствах массовой информации. После изучения фокусных групп, следует развить программу в направлении раскрытия в ней положительных аспектов реформы здравоохранения. По результатам этой лозунговой программы рекламная кампания будет адресована молодежи и посвящена фактическим понятиям в реформе здравоохранении. В этой рекламной кампании доминирующей темой по-истине будет всеобъемлющий характер здравоохранения будет доминирующей темой.

В связи с тем, что национальное радио и телевидение России играют важную роль, кампания в масштабе страны должна освещать вопросы и ответы, которые, несомненно, возникнут у российских граждан по поводу процесса реформ. В соответствии со статистическими данными, разработка и внедрение всех фаз должно сопровождаться усилиями по максимальному вовлечению российской общественности на местах, акцентируя внимание на позитивных элементах российской системы здравоохранения и проблемах, с которыми населению придется столкнуться на пути к лучшему здравоохранению. города, представляющие наибольший интерес, должны освещаться средствами массовой информации.

Второй элемент подразумевает разработку региональных и узко-местных программ, учитывающих интересы и требования на местах. Как мы знаем из данных опроса, разные регионы по разному понимали процесс реформ. Соответственно, четыре региональных офиса должны быть организованы для выполнения программ, адаптированных для этих регионов. Так, на юге России кампания по информированию населения об изменениях в существующей системе должна быть более осторожной и постепенной. На Дальнем Востоке, наоборот, содержание информации должно быть иным, поскольку население там значительно более склонно поддерживать реформу.

Важным элементом программы является акцентирование положительного опыта, накопление которого происходит в настоящее время по всей России.

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Это предполагает использование пилотных проектов и очерков, о которых мы уже говорили, для демонстрации их в качестве образцов в будущем. Таким образом, мы должны донести полно с помощью существующих прореформистски настроенных поликлиник, больниц и аптек, что перемены происходят, и что люди извлекают пользу из них.

Одногодичная программа должна быть начата незамедлительно для работы с российскими медиками и российскими учреждениями, с тем чтобы было положено начало созидательному процессу. Следует приступить к формированию групп поддержки со стороны медиков и со стороны населения, пользующегося медицинскими услугами, одновременно с разворачиванием рекламы реформе здравоохранения по телевидению, радио и в газетах, для того, чтобы "Здоровая Россия - 2000" состоялась.

Д. СТРЕМЯСЬ К КОНСЕНСУСУ: ПРЕЗИДЕНТСКАЯ КОМИССИЯ

Эффективным и часто используемым средством для достижения общественного понимания и поддержки для важных правительственных инициатив является назначение президентской комиссии. Американская история знает несколько особенно важных примеров, относящихся к службам здравоохранения и социальным службам, таких как назначение президентом Рузвельтом в 1934 году Комитета Экономической Безопасности на уровне кабинета министров, чей доклад спустя год содержал предложение, легшее впоследствии в основу американской программы социального обеспечения.

Крупная правительственная инициатива, такая как реформа здравоохранения, окажет огромное влияние на экономику страны и жизнь людей. Наряду с существенной поддержкой, может возникнуть и серьезное непонимание и оппозиция. Учреждение авторитетной заметной и доступной президентской комиссии может давать информацию о процессе, разъяснять цели правительства и давать возможность потенциальным оппонентам быть понятыми, а их замечаниям быть учтенными. Проведенное осмысленно назначение комиссии, совещания, исследования и заключительные предложения по здравоохранению России могут иметь следующее воздействие:

- Лица,принимающие решения, могут получить информацию из независимых источников и нынешней системе здравоохранения. Информация, содержащаяся в "Здоровая Россия - 2000", может быть использована как первый шаг комиссии;
- Возможно заручение поддержкой высоко квалифицированных и признанных российских экспертов в области здравоохранении в

качестве членов этой комиссии или же исследователей, консультантов, привлеченных комиссией.

- Это может убедить российских граждан в приверженности правительства проведению тщательной и открытой оценки существующей системы и альтернатив перемен и обеспечить убедительные мотивы для предложений правительства;

- Это может, как отмечалось, помочь разъединить оппозицию путем приглашения потенциальных оппонентов представить их взгляды комиссии как в письменном виде, так и на открытых слушаниях.

По нашему мнению, идеальная структура для такой комиссии определяется следующими характеристиками:

Членство. Комиссия может состоять исключительно из представителей исполнительных структур, или же исключительно из пользующихся уважением частных лиц, или же тех и других. Мы рекомендуем третий вариант, при котором значительный вес имели бы уважаемые и независимые лица, не связанные со здравоохранением, которые способны "сказать все, как оно есть". Комиссия не должна быть большой или громоздкой. Идеальной была бы численность не больше 10 человек.

Вспомагательный персонал. Основу штата составляют специалисты в следующих областях: экономика здравоохранения, финансирование, страхование как источник финансирования, клиническая медицина, эпидемиология, медицинские учреждения, медицинское образование, кадровые вопросы, информационное управление, фармацевтические препараты и медицинские материалы. В состав штата должен входить квалифицированный писатель и специалист по информации для общественности. Комиссия должна иметь полномочия брать на работу на полный или частичный рабочий день консультантов, исследователей и других технических экспертов, необходимых для выполнения ее миссии. Персонал должен иметь соответствующие его потребностям помещения и оборудование.

Доступность Комиссии для общественности. Комиссия не должна оттягивать организацию публичных слушаний по критическим вопросам реформы здравоохранения. В отличии от порядка членства, эти слушания должны быть чем более открытыми для публики, тем лучше. Ни одна заинтересованная группа не должна иметь повода сказать, что ей не удалось представить свои взгляды комиссии. В идеальном случае, слушания должны происходить в нескольких городах России и тем самым давать членам

комиссии возможность посетить медицинские учреждения по всей стране. Слушания должны стать частью общественной деятельности комиссии и быть обощенно представлены в заключительном отчете.

Исследования. Наряду с публичными слушаниями, персонал комиссии должен проводить необходимые исследования, с тем чтобы получать информацию для своих изысканий и предложений. Группа должна заниматься исследованием учреждений системы здравоохранения, рабочей силы, обучения, финансирования, организации и относящихся к ним вопросов. Очень важно, чтобы отчет комиссии давал всесторонний фактический материал для ее рекомендаций, подчеркивая особенно успешный опыт проведения пилотных проектов по стране.

Временные рамки. Какой период времени понадобится комиссии для выполнения ее задачи и достижения положительного результата, зависит, среди прочего, от способности правительства сформировать необходимую структуру, от глубины исследований, которые требуется выполнить, и от степени давления . Опыт подсказывает, что разумными временными рамками является один год. Меньший период времени будет означать меньший объем исследований и, возможно, более ограниченное взаимодействие с общественностью.

Отчет комиссии. Выводы и предложения комиссии не должны оказаться затерянными в медицинской энциклопедии. В идеальном варианте, отчет должет состоять из двух частей: заключительный отчет и сопутствующие документы. Такое разделение не означает, что исследования и другие допонительные материалы не важны. Исследования будут иметь огромную ценность для тех, на ком будет возложена обязанность осуществлять на практике программу. Как минимум, заключительный отчет должен содержать:

- письмо-обращение к президенту;
- сводка основных выводов;
- сводка рекомендаций и предложений;
- отдельные главы, посвященные каждой из основных рассматриваемых проблем, включая те проблемы, о которых шла речь в этом документе;
- упоминание о тех, кто оказал помощь при написании отчета в качестве консультанта или участника слушаний или других заседаний комиссии или консультативного совета;
- список членов и персонала комиссии и консультативного совета.

Даже после написания заключительного отчета комиссия могла бы продолжать отслежиать прогресс в периодических докладах, обращать

внимание на успешные реформы и определять важные остающиеся проблемы. Опыт США показал ценность таких мер в критические моменты национальной истории. Есть все основания полагать, что такой же благотворный эффект может быть достигнут и для программы "Здоровая Россия - 2000".

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Section I

Introduction

This Annex represents a synthesis of several earlier papers prepared for the Russian State Committee on Privatization ("GKI"). It serves therefore, as background for the conclusions described in "Healthy Russian 2000," examining in greater detail some of the options considered and rejected in that paper.

The health care sector in Russia requires unique consideration. Societal interests and principles of efficient financing must be combined to provide universal access to a basic package of care. The provision of care should be privatized or denationalized in order to promote quality care and service. Privatization strategies for Russia should thus accommodate (a) the different types of care and technology; (b) the nature of health care financing; and (c) a variety of local circumstances.

Moreover, privatization legislation must encompass a regulatory framework that will (a) protect the consumers from private monopolies at any level; and (b) protect the financial viability of investors in a highly uncertain economic environment.

The Russian health-care system is based on a regional network of hospitals and polyclinics which usually have totally separate medical staffs. The medical care system used to be highly centralized, but over the last 5 years it has been almost totally decentralized to the *oblasts*. As a result there is now local autonomy, but a lack of leadership from the federal government The system has become so fragmented that each local provider fends for itself.

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They order many of their own drugs, sometimes purchasing directly from international suppliers. At the *oblast* level leadership has been uncertain; at the local level it is almost nonexistent. The result of decentralization has not been greater competition, but greater insecurity in the health-care sector.

Outpatient care in Russia is provided through a country-wide system of polyclinics, where doctors are grouped together, similar to a "group practice" would be in the U.S. These polyclinics vary considerably size. They may include hundreds of doctors and usually include doctors in every speciality. In more rural areas, there are small ambulatory care clinics, which may have from two to five doctors. In even more remote areas, there are *feldscher* posts, or physician assistants, and sometimes a midwife.

Although this report necessarily focuses on the deficiencies of the current health care system, it attempts to not to overlook Russia's core strengths in this field. For example, the Russian system provides universal access, which is the hallmark of a modern, west European style health care system. It is essential, as free market initiatives are introduced, that the Russian government maintain its commitment to provide universal access for its citizens, with special emphasis on providing care to the unemployed, the elderly, and children. Another strength of the Russian system is the polyclinics, in which primary physicians, specialists, and medical staff together furnish primary care. These institutions are especially ripe for privatization. Russia also has a large supply of doctors, so there is no danger of being short of health care professionals. The number of doctors is a positive point. However these physicians need better incentives to provide efficient treatment and gain modern training and equipment.

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Russia undoubtedly has the potential to create a sustainable, high-quality health-care industry that can satisfy the needs of the Russian people. Russia's population is large enough to support an internationally competitive health-care industry. The population is well educated and includes a strong scientific community. Within a system that provides appropriate incentives, the future of the Russian health-care industry can be bright.

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Section II

Hospitals and Polyclinics

Although often fraught with dire predictions about the social implications of changing the system, the health-care sector -- specifically hospitals and polyclinics -- does not require ownership and management by the government. Experiences in many other countries indicate that privatization or denationalization of these facilities encompasses a wide range of possibilities. In this section we explore the financial and "business" implications of denationalizing hospitals and polyclinics, and in a later section we explore the legal frameworks under which such changes might occur.

We strongly believe that the aspirations of the present Russian system -- promoting health through quality care, that is efficiently provided, and on a universal basis responsive to clients' needs and desires -- are goals that can be achieved through privatization. The new system should encourage different types of care to grow, such as day surgery centers, specialized clinics for women and therapeutic categories. The law should not discriminate in any way against new approaches, which in many cases will provide better quality and more efficient care.

2.1 Benefits of Privatization

Successfully carried out, privatization or denationalization of hospitals and polyclinics would have these effects:

- Preservation and enhancement of universal access and improvement in the quality of health-care provided to all Russian citizens by making them more equal customers in a private sector system, thereby providing for greater equality.
- Enhancement of patient satisfaction by providing a greater range of health-care service providers to patients.
- Decentralized, autonomous management and competing health-care institutions promoting: better health standards by eliminating the widespread inefficiencies in the provision of medical care, and greater responsiveness to client's needs and desires.
- Budgetary discipline among providers that will ensure their economic viability.

2.2 How to Privatize

2.21 Ensure a Clear Regulatory Framework

Recent legislation, described in detail in Section IV, provides extensive guidelines for Russia's privatization program. The Presidential Decree of December 24, 1993, is perhaps the most specifically relevant to the health-care sector. With the exception of certain advanced medical training centers, scientific research institutes, orphanages, nurseries and homes for the elderly, it allows the privatization of hospitals and polyclinics.

2.22 Privatization Options and Methods

We believe that the health-care delivery system requires unique consideration because of its vital social importance. In forming the following recommendations for privatizing and denationalizing hospitals and polyclinics, we were cognizant of the uniqueness of the health-

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care sector and of the Russian experience. (More detailed legal analysis on options and methods is contained in Section IV of this paper.)

We believe that straightforward ownership should be encouraged and supported. Despite the emotional implications often associated with health-care, it is a service fully capable of being supplied by privately-owned firms. Privatization can result in better care, lower costs to patients, and enhanced patient satisfaction. Improving hospital facilities will take a fair amount of capital, something that most hospitals have in short supply. There are four ways to generate new capital: borrowing, increased state contributions, sale of assets and improved efficiency. With, in the near future, limited private or public capital available for this purpose, and the sale of assets likely to be limited, the crucial task now is to improve efficiency. At present these improvements would release cash now tied up in hospital operations. It should be possible to achieve certain efficiencies in the short term. However, in the longer term, it is our view that the only way to ensure that hospitals have efficiency incentives is to separate the providers from the purchasers of care. This is the intentions of the health reforms in place and it may occur naturally as the Sick Funds (insurance funds) extend coverage to the whole population. At present the purchaser and the provider are not fully separated, so the incentives reward inefficiency and poor management.

In addition to for-profit hospitals, we believe that privately controlled, non-profit of "charitable" hospitals should also be encouraged and supported. These could be "owned" by civic charities, labor unions, religious orders, fraternal societies, academic institutions and similar organizations. In this regard, Russia could consider creating Self-Governing Hospital Trusts (SGHT) through denationalization of state hospitals, as the United Kingdom, Israel and the Scandinavian countries have recently done. Through this process, hospitals become

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"public trusts" which are not-for-profit organizations. This status essentially removes the management of the institution from the government.

Such hospital trusts run on variable income from the sale of services rather than on fixed budgets based on inputs. Because money moves with patients, SGHTs must focus their energies on the quality of their medical care and patient satisfaction if they are to remain viable. Under this system, control over the allocation of health-care funding of hospitals shifts from bureaucrats and hospital consultants to those who purchase the services in the community. To successfully make the transition from being state run to a semi-autonomous institution, like an SGHT, hospitals need to have a management capable of organizing and running the hospital efficiently, basic information systems for tracking cost and monitoring outcomes, a sound financial basis and an adequate level of equipment, medicine and staff for the patient population.

Polyclinics could be privatized by allowing polyclinic doctors to take ownership of their practice. This would mean transferring the business and operations of the polyclinics to the polyclinic doctors. The clinics would become non-profit institutions where the doctors have decision-making power over what to do with their premises, which specialties to provide, employment, services provided, number of doctor hours available in the clinic or home and whether to do some fee-paying extra services (*e.g.*, orthodontics). Government would rent or lease the land and building assets to the practice.

Besides ownership, the government needs to change its health-care payment mechanism. Government reimbursement must be changed to a per capita basis (per person, weighted for demographic factors), so that it will be possible for patients to choose the polyclinic they

wish to be registered with and attend regularly. The patient should also be able to choose which doctor within the polyclinic they wish to see, as their main doctor.

Pilot projects along these lines are being carried out at present in three *oblasts*, and it makes sense to evaluate the pilot schemes before expanding the concept. In theory at least, the system would provide an incentive for the polyclinics and individual doctors, to become more patient-friendly, in order to attract the largest number of patients and thus funding. Within constraints set down by the government, polyclinic doctors managing the clinic (or solo practices) would be able to choose how to spend their revenues. Being able to pick and choose where to spend their profits would give polyclinics a further incentive to be efficient and to provide services for which there is greatest demand.

In order to ensure that all public health needs are met, the government could consider stipulating a list of services the clinic must provide for its population, and that the polyclinic facility be used for providing health-care services. The government could also provide bonus revenues for polyclinics that hit certain targets, especially in preventative medicine (such as immunization, cervical screening, *etc.*).

We would strongly recommend that any hospitals or polyclinics that remain under government ownership contract out the management of the enterprise, property and equipment from the private sector. Furthermore, for all hospitals owned by not-for-profit organizations, or retained by the municipal or state governments, we recommend that services also be contracted out to private organizations. this would minimize inefficiency and keep costs down, thus benefitting customers. There has been world-wide success with privatizing hospital management, food services, laundry and linen services, equipment supply

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and maintenance, and specialized medical services such as radiologists, anesthesiologists and medical laboratory services.

The Boston Consulting Group ("BCG"), in a recent paper, put forward an opposing view of privatization. They suggested that the state should retain the majority ownership of hospitals for the time being. According to BCG, there is no obvious buyer or market value for many hospitals. They are not completely against privatization, but would prefer for privatization to move more slowly after the government has enacted strict guidelines for prospective buyers. Further, BCG believes that hospital managers should be given greater authority over decisions made in their hospitals, including rental of space, and wages. BCG also thinks that the government should allocate more resources to the health sector.

This view has several problems. First if the government kept majority control over hospitals, the reform process could be stalled. The current problems with the health-care system stemmed from government control. Maintaining the state's predominance in the health sector then would put the cause of the problem in charge of changing it. Similarly, Russian hospital managers oversaw the creation of the present inefficient system. At present they do not have the skills or training necessary to institute major reform efforts on their own. Finally, as indicated earlier, the state has limited resources. Basing reforms efforts on government monies then seems unrealistic.

2.3 Impediments

There is no question that the following impediments to a well functioning, cost-effective, high-quality system of medical care provision can best be resolved in the context of privatization. Among the most visible impediments are these:

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2.31 Inhospitable Economic Environment

Hospitals and polyclinics in the Russian Federation suffer from the same economic problems as other institutions struggling to emerge from state ownership. They suffer from financial, logistical and managerial difficulties, all of which impair the delivery of health-care services and increase inefficiency and costs. Financial viability and debt problems are also major inhibiting factors because hospitals and polyclinics in Russia have not been operating on a commercial basis. The economic situation is the greatest threat to stable funding. If enterprises fail, there will be no taxes for the budgets of cities or districts, and there insufficient funds to out into a 3.6 percent obligatory insurance fund.

There have been marked demographic changes in Russia directly related to the health-care system, such as a plummeting birth rate and a rapidly growing population of elderly poor, especially in rural areas. The health care system has not adequately responded adequately to these demographic changes. The system has created its own impediments to reform.

With a few exceptions, such as home visits, the system does not allow the consumer input, and consumers are encouraged to assume a passive role by providers. A 1988 survey found that over half the people questioned (sample size 54,000) were dissatisfied with the system. Their most frequent complaint was the long wait for care. Consumers have no way to complain if they are given shoddy care. In fact some doctors and nurses require extra payments "tips" if patients want extra comforts or services.

Because the system is so unfriendly to consumers, individuals have little sense of responsibility for their own health. This passive attitude will make it more difficult to install

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market reforms, because discerning consumers keep the market competitive. An apathetic population will also make it difficult to move into preventative medicine, which requires effort by the patient. Parents are not even given their children's immunization cards because doctors assume that parents will loose them.

2.32 Insufficient Funding

Overall health expenditures as a percentage of GDP appear to be very low, around 3 percent, compared to 8 percent or more in most western countries. There is also considerable debate about the reliability of the statistics on which the Russian figure is calculated.

2.33 Antiquated Equipment and Methodology

Twenty years ago, Russians felt that they had the best health-care system in the world -- at least in terms of universal access and coverage. However, the system has become frozen in time, and in many respects, has even regressed in recent years. It has become inefficient, wasteful, antiquated, based on curative medicine instead of prevention, and with a few exceptions, unresponsive to consumer needs and wants. The conservative nature of Russia's medical establishment can be seen in doctors' views on preventive medicine. There seems to be much theoretical support for prevention, especially among pediatricians, but in practice there seems to be only very conservative efforts, like regular physical exams and screening for children's deficits. Community efforts and school programs seem non-existent.

The lack of modern equipment and medicine is an example of one of the systemic flaws in the Russian health-care system. Most hospitals and clinics are ill equipped, use antiquated

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practices (*e.g.* manual blood counting) and do not receive required medicines on time. There are reports of major surgery conducted without anesthesia. On the other hand, advanced tertiary care equipment, such as MRI scanners and lithotriptors, are available. Equipment seems to be a status symbol, both for providers and patients. That tendency may be part of the reason that physiotherapy, which requires unusual equipment is very popular in Russian medicine.

Not only is medical equipment lacking in the Russian health sector, modern information systems are absent as well. Data is still mostly collected by hand. Medical records, at least for inpatients at hospitals tend to be well documented. The quality of medical records for outpatients is unknown. Financial records also hand written. As health care finance systems become more complex, a more efficient means of dealing with financial information will be needed.

Medical personnel also need to change to reach western standards. A large proportion of doctors, nurses, administrators and technicians in hospitals and clinics need to update their education and training to learn how to apply more effective medical protocols and health care management techniques. Not only do medical professionals need to update their training, there are too many of them. There is approximately one doctor for every 250 people.

The oversupply of doctors suggests that doctors are being used to perform many functions that nurses could do more cost-effectively. Hospitals also have a large amount of excess capacity. There are three times as many hospital beds per populations (13.9 per 1000) as there are in the U.S. and the average length of hospital stays (24 days) is three or four times as long. Russians average 9 to 10 outpatient visit a year, which is also very high. Because

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hospitals are inefficiently used, they take up a disproportionate part of the health care budget. Hospitals take up 65 percent of the health budget. Primary care receives only 20 percent and public health only 3 percent These inefficiencies consume resources that are needed elsewhere to reform the system.

The over-utilization of hospitals is primarily due to: (a) financial incentives that encourage over-utilization; (b) failure to adopt more up-to-date standards for hospital length of stay; and (c) failure to distinguish between acute-care patients and long-term or custodial care patients. As a result, hospitals are much larger than necessary, use more staff and waste resources. Hospital and polyclinics rarely work together. Usually polyclinic doctors and hospitals in the same area do not work in the others' facility.

2.34 Substandard Conditions

Hygiene standards are a major problem in most hospitals and clinics. Additionally, the long hospital stays create an environment in which general infections spread rapidly. Russian hospitals, especially maternity wards, suffer from a much higher degree of secondary infections than most western medical institutions. The levels of health as measured by certain key variables such as life expectancy and infant mortality are below western norms. Life expectancy for males has stayed at about 63 years for the past three decades. The infant mortality rate is about 18, over twice that of most of Europe. Maternal mortality is high and the overall death rate, at about 14/1000, is also twice that of most of Europe.

Children get special care, with expensive equipment for testing, swimming pools for hydrotherapy, routine examinations by a battery of specialists beginning after they are one

month old are just a few examples. However, even though children receive so much care a high proportion of Russian children tend to get sick. The high number of sick Russian children, in spite of the emphasis that the Russian health system places on pediatrics, is another indicator of the inefficiency latent in the system.

The leading causes of death are heart disease, strokes, cancer and accidents/violence/ homicide. These causes of death are largely preventable, stemming form smoking, drug and alcohol abuse and a deteriorating environment. There have been a few anti-smoking ads on Russian television, but the effort has been minimal compared with the barrage of cigarette advertising.

2.4 Considerations for Optimal Privatization

In our judgement, adoption of the following measures would provide a practical and workable framework, as well as incentives needed to attract investment in a progressively privatized health care delivery system.

2.41 Maintain Strong Focus on Improved Health Care

The increased efficiencies of a privatized health care system will result in financial savings that must be devoted to improving the quality of health care for all citizens. Given that health care statistics, life-expectancy and other health care indicators are moving in the wrong direction, GKI and other proponents of privatization must make it clear that the primary goal of the privatization effort is improved health care for the population. This is both a humanitarian and political imperative. Effort should be made to coordinate foreign

aid programs targeted on health care with the privatization effort in order to maintain the primacy of this focus.

2.42 Establish Compensation Mechanisms

In most situations the government sets the fees and compensation mechanisms for institutions operations under public finance. Consequently, as medical institutions become private, they need to be assured that compensation mechanisms will protect their economic viability and offer a fair return on their investment. Such mechanisms and structures are not yet in place, although stipulated in the Decree issued on October 11, 1993.

2.43 Provide Equal Access to Patients

Private and denationalized institutions need to be guaranteed the same access to patients and resources as public institutions. In the current system, private institutions have no access to publicly financed patients. This may be a serious matter especially during the period of transition when authorities with vested interests may try to discriminate against private entities.

2.44 Demonopolize

The monopolies that dominate the Russian health scene need to be broken up. Replacing state monopolies with private monopolies should absolutely not be the result of any privatization system.

Large polyclinics (*i.e.,* those with 200 employees of more) should and can be broken up (on the same premises) into smaller, more specialized, privately-owned units, including those that provide administrative and technical support to care providers. These large polyclinics should become private medical centers, a common and efficient concept for delivery of community care in other developed countries.

To aid in the push toward smaller, more efficient institutions, hospital mangers should be given training on current administrative methods and given more managerial control. Today hospital mangers are unable to determine staffing levels, wages and trade-offs between wages and treatment.

2.45 Offer Incentives to Potential Investors

The Russian government should conduct a proactive and extremely thorough search for investors in the health care industry. This search should include, but not be limited to, leading hospital chains, franchisers, and other respected investors, both local and foreign. Russia has some special, high reputation hospitals which could be privatized by sale to for-profit institutions. The government should consider suitable tax credits and equitable state funding for services provided by private and public hospitals and polyclinics.

2.46 Develop Training and Expertise

Substantial training and support will be required to upgrade the Russian health care sector to modern medical techniques and the demands and methods of operating in a private sector environment. We recommend that a comprehensive management and medical training

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program be established as an integral and complementary element of the privatization process.

Russian medical training needs to be revamped. In Russia, doctors have a six-year course of study after high school. American doctors average twelve years of training after high school. During this time Russian doctors follow some degree of specialization and graduate as a therapist or pediatrician. Most graduates will then do one year of additional study or speciality fellowship at a hospital and become a specialist. Seven years after high school a doctor could be considered a cardiologist of a surgeon. This system of training produces a large number of doctors that have insufficient training. It was able to provide far-flung areas with medical personnel, but was not able to ensure quality of care.

Physicians need other training in order to privatize the medical sector. For example, in private polyclinics, doctors would need training as small-scale businessmen to help them run their practices. They will also need software packages and other support to assist them in tracking and monitoring their costs and patient flows.

The use of modern medical techniques could reap substantial rewards for medical institutions. For example, switching to automatic rather than manual blood counting or using anti-ulcerants instead of hospitalizing ulcer patients would free up time and manpower that had been devoted to out moded techniques. New equipment is not sufficient to change the system. however. A change of attitude is also required so health care professionals begin to think about efficiency and shortening hospital stays.

Ensuring the continuity of services as the health care industry becomes privatized is vital.

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In areas where a single hospital or clinic is the sole provider of services, it is particularly important to undertake intensive preparation for the transition to private ownership(s). This preparation must include efforts to identify steps that must be taken to create an economically viable and well managed facility and to carry out those steps as part of the privatization strategy for that hospital or polyclinic. Contracting out the management services would be a useful transitional phase for those enterprises whose economic viability is doubtful. Managerial expertise is in general very weak. This weakness is becoming more significant as the health care sector changes.

On the positive side, there is a great deal of entrepreneurship already in the health care system. Although still on a small scale, the principles of private practice and fee-for-service for some services are well established -- and *de facto* accepted. In fact, there is greater variety from one region to another than had been expected, both in clinical arrangements and in approaches to financing. Moscow has had private practice clinics for 30 years. In other areas, charging for special services is a well established practice, if officially frowned upon. For example, in Tver a significant number of physicians have private practices as means of generating extra income. There are also private sanatoria near Tver.

Certain kinds of "alternative" or specialist care has always been accepted as "private practice" as well. In Tula, hospitals were renting out space and equipment to doctors that have their own private practice. Charging for expensive diagnostic services is routine. Tula's diagnostic center became so lucrative that the city and *oblast* government began arguing over who should have control of the center's operations. Where private clinics are available, consumers much prefer to go to them than public clinics, according to anecdotal evidence.

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On an individual level, compensation of doctors varies across the board. There is an official compensation system based only on grade that is ignored, instead hospitals have developed certain incentives. For polyclinics these incentives include extra pay for extra shifts, extra pay for administrative work or being chief of a department and extra pay -- or penalties -- based on quality and quantity of work. Hospitals use different incentives, for example, hospital doctors receive extra money for house calls. One hospital in Ekaterinburg even uses a productivity-based reimbursement formula which divided a percentage of insurance receipts among the doctors in each speciality group. Doctor salaries can range from 50,000 to 500,000 under this formula. Local initiative is alive and well. On the negative side, there appears to be a growing gap in the system between the rich and poor, making primitive payment systems harder on poor people.

2.47 Address the Special Issues of Rural Areas

Privatization should proceed in ways that do not disadvantage rural areas more than their present status. By the same token, however, we believe that the special problems of remote and impoverished areas need not distort the privatization operation as a whole. The privatization process should proceed nationally, with the special needs of these areas addressed financially and medically as part of the Russian society's overall safety net.

We recommend that the fee structures for health care services under the voluntary and compulsory insurance systems allow for regional variations. The use of such market-based mechanisms will allow for financial incentive for doctors and health care providers to furnish equal medical care to rural of remote regions in Russia, thus. avoiding undesirable disparities in the quality of care and services. The U.S. medical insurance industry makes widespread

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use of geographically determined "customary and reasonable" fees in paying health care providers.

2.48 Develop the Role of Insurers

Special attention needs to be given to insurers in the health care sector and their relationship with providers. As the main purchasers of care, instead of the state, these institutions can constitute the "front line" in reducing the role of the state in the management and provision of care.

2.5 Territorial Medical Associations

In the late 1980's, a small number of "Territorial Medical Associations" (TMA's) were established to manage and provide treatment and preventative care in different geographic regions. This experiment took place in three areas: the city of Saint Petersburg, Kemerovskaya Oblast and Samarskaya Oblast. Other cities have been subsequently encouraged to experiment on their own because of on going changes in the Russian administration and economy. Financing under the TMA mechanism is marked by a transition from budgeting by line inputs to financing by standard definition of needs. Moreover, the TMA's have the option of obtaining additional sources of revenue through the sale of services to the population at large and enterprises.

The concept behind the TMA model is closely related to the concept underlying Health Maintenance Organizations ("HMO's") in the U.S. The HMO becomes a "budget holder" and assumes the responsibility to provide care for an enrolled population. The TMA

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mechanism in Russia postulated radical changes aimed at decentralizing the management of medical institutions and increasing their efficiency and responsiveness to consumers. A TMA may be comprised of polyclinics (for adults, children stomatological diseases and so on), women's consultation stations, dispensaries, hospitals, maternity hospitals children's sanitoria, emergency care stations and other services. The structure of each particular TMA is defined by local circumstances.

Polyclinics also played a leading role in the TMA's. Polyclinic-based TMAs are primarily budgeted according to a capitation formula based on the demographic characteristics of the registered population. These polyclinics have become "budget holders": they are allocated funds for medical services provided based on the sale of such services, rather than on fixed budgets based on inputs. Thus consumer choice rather than bureaucratic decisions dictates the allocation of financial resources in the primary health care sector. As a consequence, inpatient care at hospitals has declined, but overall medical services have increased. Despite flaws which need to be rectified, the TMA experiment has been institutionally and politically bold, and conceptually innovative by international standards.

2.6 Financing of Hospitals and Clinics

Traditionally the health care system was financed through budgetary funds and the support of industries, many of which still have their own parallel health care systems. In the old centralized system, the budgetary funds largely came from the center (Moscow).

Central funding is now nearly non-existent, but local budget support and help from local enterprises still form an important part of funding. Other sources of funding are municipal,

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rayon, oblast budgets and sources like the Chernobyl fund. However, a major basis of funding was radically changed last year with the creation of insurance funds. These are in the process of being implemented, and even without legal changes in the health care system, they are beginning to force changes in medical practice.

With the current unstable economic situation, budget and enterprise support for the health care system will likely shrink. The new compulsory funds will become the major source of funding. Patient fees, long a small part of extra funding for physicians and the system as a whole, will probably become more important as privatization becomes more accepted. However, free health care remains a strong belief among the Russian people. This conviction will make it more difficult to increase the patients's share of the health care bill. The entire system of health care financing is in the process of radical change.

Under the emerging insurance system, the government's role in financing health care will remain large. The compulsory mechanism, planned along the lines of the German and Dutch "Sick Funds," appears to be conceptually consistent with many major western models, aims first and foremost to mobilize more resources for the health care sector. There have been mixed reviews -- based mostly on insufficient reimbursements -- on the compulsory insurance fund. There were complaints that the reimbursement rate was too low, did not cover costs and did not take inflation into account. Obviously these concerns will have to be addressed before the insurance systems can function properly. When completely implemented, the insurance system can fundamentally change the structure of health service organization, management and delivery consistent with most OECD nations.

Ultimately there will be gains in the quality of care and service. The funding mechanism is

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essentially a transparent "earmarked" tax on payrolls, reserved specifically for health expenditures. The central institutional feature is the creation of separate, social compulsory insurance at the national and territorial levels. The funds are to be established as independent, non-commercial finance and credit institutions. The national fund has the function of achieving cross-regional equity objectives.

However, the new mechanisms are not yet functioning fully in many regions. It will take some time before the insurance funds are fully in place, and the system has adjusted to the introduction of insurance. Legislation allows the insurance funds to purchase services from independent providers of care, or to actually own care facilities, thus becoming HMO's. Voluntary insurance programs under the new legal framework are also developing and provide coverage over and above the compulsory program. Under the health insurance statute, the issue of insurance company ownership is open. Therefore, enabling legislation for privatization should address the various ownership possibilities including for-profit and not-for-profit (mutual) health insurance organizations.

We have not attempted to address the full subject of health insurance here. However, in the context of privatization, the key issue is whether the insurance funds can function effectively as separate purchasers of care. Their financial viability therefore, is a critically important element of successful financing of increased health care expenditures. Under the German and Dutch systems for example, the Sick Funds are tightly regulated by their respective governments out of concern for their financial solvency. Operating in conditions of high inflation, as Russia is currently experiencing, underlines dramatically the importance of the financial viability of the insurance funds.

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Besides financing the health industry itself through insurance, there is also a need for low-cost financing for basic medical equipment. Once providers become non-profit and tax-exempt, they should be eligible for loan guarantees, interest-free financing through leasing, tax exempt donations and sales of below-market-value equipment. The priority is to assist institutions that wish to acquire basic equipment, with an emphasis on equipment that increases efficiency or effectiveness, or helps with preventive care. Much of this equipment should be eligible for export credits, which comprise a large share of western aid designated to Russia. At present the ordinary hospital or polyclinic has difficulty capitalising on this benefit, because they are not familiar with the process of securing these credits.

In the U.S., from 10-15 percent of the operating budgets of hospitals and clinics are funded through tax exemptions to the providers of care and the donors of contributions of money, credit and equipment. In Russia, foreign manufacturers of health care equipment and medicines are anxious to secure a foothold in the Russian market -- and are taxed at high rates. It is critical that such tax exemptions be made available. These exemptions could furnish an important source of funding for hospitals and clinics.

Section III

Pharmaceutical Sector

The dismal state of the pharmaceutical production and distribution in Russia is due mainly to the failure of central economic planning. Paradoxically, an already difficult situation was made at least temporarily worse by the breakup of the Soviet Union and the loss of the Union's COMECON trading partners. Under the prior political arrangements, the pharmaceutical system was planned supra-nationally across Central and East Europe. The breakup left Russia critically short of vital production facilities.

Many of the relevant issues apply to both pharmaceutical manufacturing and distribution. Where appropriate, we address these issues as they apply to the entire pharmaceutical industry. However, issues specific to the particular sectors suggest that manufacturing and distribution be addressed independently.

This section highlights the benefits of a privatized pharmaceutical industry, outlines serious impediments to Russia's ability to meet its pharmaceutical needs in a reliable and cost effective manner and offers considerations for legislation and other administrative and policy measures that could help achieve the most effective pharmaceutical supply system.[1]

3.1 Benefits of Privatization

Successfully carried out, privatization at all levels of the drug supply and distribution system would have these effects:

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- Competitive forces would help promote the unobstructed flow of needed pharmaceuticals.
- Greater attention would be focused on the costs of production and distribution. The result should be significant gains in labor productivity.
- Most important, a competitive, cost-efficient pharmaceutical sector would not only lower the cost of drugs and progressively lower the need for government subsidies, it would widen the availability of drugs, thus lessening the demand for more intensive and expensive forms of medical intervention.

3.2 How to Privatize

3.21 Ensure a Clear Supporting Legal Framework

Recent legislation, described in detail in Section IV, provides extensive guidance for Russia's privatization program. The Presidential Decree of December 24, 1993, is perhaps the most specifically relevant to the pharmaceutical sector. With the exception of those who produce or sell narcotics, it allows the privatization and pharmaceutical producers, wholesalers and retail pharmacies. Clear provisions to protect against the expropriation of privatized enterprises by the government, protection against discrimination against foreign interests, provisions to allow the expatriation of earnings and the free sale of property within Russia, would help to advance the aims of the new legislation It should also be made clear that private interests are not barred from majority of complete ownership of a privatized firm.

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3.22 Privatization Options and Methods

We believe that considerations surrounding the pharmaceutical industry at all levels -- manufacturing, wholesale distribution and retail -- are sufficiently analogous to other industries being privatized that options and methods previously used can be applied here as well. Obviously, the enabling legislation itself must take into account the particulars of pharmaceutical as opposed to other industries. More detailed legal analysis on options and methods is contained in Section IV of this report.

Pharmaceutical Manufacturing

3.3 Impediments

These is no question that the following impediments to a well functioning, cost-effective pharmaceutical manufacturing sector can be best resolved in the context of privatization. Among the most visible impediments in the manufacturing sector are these:

3.31 Inadequate Manufacturing Base

Historically, as noted, the Soviet Union relied upon its former COMECON partners to supply the bulk of its final-dosage form pharmaceutical needs. It was unprepared for the effects of COMECON's dissolution. After the collapse of communism, the rather well-developed pharmaceutical sector supply systems of Central and East Europe turned increasingly to the West for trading partners, who they judged to be better financed and more reliable than Russia and its sister republics.

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In addition, Russian producers lack expertise in the production of many pharmaceuticals. Under the previous system, Soviet producers focused mainly on the production of substances, while the production of finished forms was left to the Eastern Europeans. This system helps to account for the fact that even today imports from Central and East Europe make up nearly 40% of the market. Thirty percent of essential drugs were never produced in Russia.

3.32 Obsolete Plants

No new plant has been built in Russia in over fifteen years; some actually date from the turn of the century. These plants are extremely inefficient. They also pose significant risks to the consumers of their inconsistent and often impure products. People surrounding these obsolete plants are also at risk from existing and continual environmental destruction. Some western manufacturers who have observed that state of these facilities believe that the best hope for internal production is to start anew.

3.33 Antiquated and Excessively Complex Product Ranges

In a given therapeutic category, leading Russia products are often generations behind leading western products. Western companies are often unwilling to supply newer licenses, both for economic and quality control reasons. Some Russian companies produce as many as 150-200 different products, creating complexity and increasing costs and the risks of contamination.

3.34 Inefficient Organization Structures

The ratio of indirect to direct production employees is far too high. At the same time, marketing departments remain nonexistent or ineffective.

3.35 Inadequate Quality Controls

Only rarely does a Russian manufacturing facility operate in conformance with internationally recognized Good Manufacturing Practices ("GMP"). This failure not only constitutes a danger to public health, it effectively precludes the possibility of building a successful drug export market. With similar consequences, drug quality standards are suboptimal and not uniformly applied. Adopting GMP and updated quality standards will provide privatized firms with the obvious benefits of expanded market opportunities.

In contrast, the approval system for new drugs, which tended to be insular and inflexible, is changing dramatically. On February 15, 1994, the Russian Ministry of Health and the U.S. Food and Drug Administration reached a final agreement on a plan to permit the marketing of products in Russia that have reached approval by the FDA. It is possible that similar agreements will be reached with major European regulatory authorities.

3.36 Persistent Foreign Debt

A potentially serious deterrent to foreign cooperation and investment in Russian pharmaceutical production is the persistent outstanding debt owed by the Russians for supplies purchased abroad. While the payment of these long-standing obligations is not a

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prerequisite for privatization, positive action would vastly enhance the confidence of potential partners in investing in or collaborating with the privatization of Russian medical sector enterprises.

3.37 Debt Among Enterprises

Management of existing debt at all levels of the system and developing the mechanics to avoid a similar situation in the future, is an important concern in privatization.

3.38 Inhospitable Economic and Policy Environment

Structural problems are multiplied by the difficult economic and policy environment in which drug producers must conduct business. High levels of receivables, rampant inflation, and the unavailability of credit are problems which, while not specific to this sector, nonetheless affect it tremendously.

3.39 Emerging Legal Structure

There is perhaps no greater deterrent to privatization and foreign investment than the lack of a consistent legal structure to undergird the formation of private enterprise. Legislation described in Section IV, demonstrates Russia's determination to address these concerns.

3.4 Considerations for Optimal Privatization

In our judgement, adoption of the following measures would provide a practical and

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workable framework as well as incentives needed to attract investment in a progressively privatized pharmaceutical production system.

3.41 Offer Incentives to Potential Investors

The law on Foreign Investments in the Russian Federation guarantees to foreign enterprises at least the same rights of intellectual property as apply to Russian citizens and enterprises. While no additional legislation appear necessary, it would be helpful to provide more detailed elaboration of patent, trademark and copyright protection. Besides normal business risks, western producers fear the legal and public relations liabilities which could result from their involvement in companies making inferior products or polluting the environment. American companies, in particular, fear that a disaster could expose them to tremendous liabilities, not just in Russia, but also in the U.S.

3.42 Offer Incentives to Potential Investors

The government should conduct a proactive and extremely thorough search for investors in the pharmaceutical sector. This search should include, but not be limited to, leading to international research-based manufacturers, generic manufacturers and other respected investors, both domestic and foreign. The government should consider suitable tax credits, guaranteed purchase agreements, assistance in locating suitable property and indemnification against environmental risks.

It is crucial that privatization of existing enterprises go beyond a simple transfer of ownership. Privatization can only succeed if new owners have a greater interest in the long

term success of the enterprise. Independent, profit-driven investors -- whether they are Russian or foreign -- are likely to manage for future as well as current, profitability.

While privatization can provide new owners with the incentive to restructure, it is of utmost importance that they also have the authority to restructure. In particular, they should have the authority to fire management and employees if necessary and change the product portfolio. (In cases where particularly critical drugs are to be discontinued, the government might place restrictions or require some form if advance notification.)

Inflation creates another barrier that foreign investors have to surmount before investing in Russia. Some pharmaceutical producers try to soften the impact by using dollars as the basis for internal bookkeeping. If all costs are converted to dollars at current exchange rate, the 30 percent markup can more or less preserved. Such a practice is apparently illegal. Nonetheless, companies need to be at least partially insulated from the effects of inflation on margin calculations. One solution would be to allow the use of inflation adjusters in calculating the costs upon which are based. At the very least, companies could be allowed to use current rather than time-of-purchase exchange rates for calculating the margins on hard currency purchases (*e.g.* active substances).

Even disregarding the effects of inflation, it would seem that the current cost-plus pricing system sends all the wrong signals to current and potential investors. Unless the market is highly competitive, producers have little incentive to improve efficiency, given that they can pass costs along to consumers. At the same time, the 30 percent cap limits the amount of profit available for reinvestment in an industry in dire need of restructuring, and places the industry at a disadvantage in competing for investment capital.

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3.43 Develop Training and Expertise

Although some factory directors are prepared to take on the role of a private entrepreneur or manager, these skills and attitudes need to be nurtured and developed. Substantial training and support will be needed for manufacturers to adapt to private sector methods and demands.

3.44 Avoid Long Term Tariffs

The imposition of tariffs to protect local production could result in lower quality, higher cost products and should be avoided. Selective tariffs could in theory be used to provide temporary protection for specific new investments. This policy option should however, be used with the utmost caution. Such tariffs could easily lead to the government and consumers purchasing over-priced, lower quality pharmaceuticals. Even providing a mechanism for introducing such tariffs may be opening Pandora's box.

Russia currently allows tariff-free imports of finished forms, while placing tariffs on imported active substances. Not only does this policy fail to protect local producer, it actively discriminates against them. Tariffs on active substance imports need to be eliminated. The same is true for tariffs on packaging materials, production equipment and other items necessary for pharmaceutical production.

3.45 Integrate Quality Improvements

Consistent with our recommendations in Section 2.41 about health care quality

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improvements as an integral and complementary element of the privatization program, we recommend that health care sector aid from foreign assistance agencies be used to provide higher quality and more modern pharmaceuticals to Russian citizens. This will meet both the medical needs of the population and the needs of the privatization program as it enters into this politically sensitive field.

3.46 Additional Policy Changes

While not needed to accomplish privatization, important changes are needed to create an environment in which privatization can flourish in the pharmaceutical sector and which are critical to the long term success of the industry generally.

3.47 Establish and Enforce Production and Quality Standards

Considering the obsolescence of Russia's manufacturing and distribution base, the prospect of achieving compliance with GMP standards, Good Laboratory Practices ("GLP") and Good Clinical Practices ("GCP"), at least in the short term, is not great. Nevertheless, if Russia's pharmaceutical sector is to achieve international recognition and ultimately develop a profitable export market for drugs emerging from research within the Republic, it must begin to incorporate these guidelines among its regulatory requirements and encourage, if not initially require, conformance.

Companies wishing to export will increasingly discover that non-GMP production is of little interest to prospective buyers. Eventually, the Russian government should also require that the drugs it purchases be produced in accordance with GMP standards, and set a timetable

for reaching GMP in the future. Special tax incentives for investments in GMP might be considered.

3.48 Remove Needless Barriers to the Introduction of New Therapeutic Agents

As noted earlier, the Russian Ministry of Public Health has formed an agreement with the U.S. Food and Drug Administration to facilitate the marketing of U.S. approved drugs. Similar arrangements should be made with the regulatory agencies of other countries in whom the Ministry has confidence.

By accepting drugs that other countries have approved, Russia is opening its market to a wide variety of drug that had been in the Russian market previously. Besides injecting needed new drugs into the health sector, this move will also increase competition within the Russian pharmaceutical manufacturing market. Increased competition will hopefully shrink old monopolies and deter new ones from forming. At the same time, it is important to build on the strength of the Russian regulatory capabilities, particularly to evaluate new therapies developed within the country. The government is working with a number of international organizations toward that goal.

3.49 Use Government Purchasing Power More Effectively

The Russian government is in a position to behave as a large HMO -- *i.e.*, to use its purchasing power in negotiating with foreign and domestic pharmaceutical producers. Not only price, but also quality and consistency should be taken into account in evaluating bids for large purchase contracts, or even for preferential access to the Russian market.

Government purchases should generally be limited to essential drugs. Decisions should be made as transparent as possible, and the negotiating/decision process should be handled by an independent authority subject to the strictest ethical standards and control.

Three options should be considered for the sale and distribution of drugs covered by government price negotiations:

- Producers could sell drugs through normal channels at the negotiated price. This option is the easiest to implement and the most difficult to subvert.
- Producers could sell drugs through normal channels at a discount chosen by the government. The government would then reimburse producers for the difference between the negotiated and the discounted price. This option is administratively complicated. In addition, producers would reasonably fear the government might not follow through with reimbursement, or might reimburse late, using rubles made less valuable by inflation.
- Producers could sell drugs through normal channels at the negotiated price, but consumers would pay a discounted price at the pharmacy. The pharmacies would be reimbursed by the government. While not quite as complicated as the second option, this choice would still require a reimbursement bureaucracy. Non- or late reimbursement would be a real danger.

3.410 Provide Incentives for the Production of Essential Drugs

To lower the humanitarian and economic costs of ineffective treatment, the government should come to an agreement on a list of essential drugs based on the list promulgated by the

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World Health Organization. The list could be used to furnish incentives for existing and newly privatized operations to meet pressing needs. This list should not become the basis for limiting the market to Russian producers.

Apparently there is considerable support for requiring local production of so-called "strategic" drugs. Any discussion of strategic drugs should be viewed with suspicion. Strategic drugs might include drugs which Russia would need, but might not be able to obtain, in an international war or crisis, or an important drug produced by a monopolist, foreign supplier, upon which Russian fears being dependent.

Russia cannot afford to force or maintain inefficient local production based on a fear of international isolation. If such fears absolutely need to be addressed, then strategic stockpiles of selected drugs, purchased at the lowest possible price on the domestic or international market would be preferable to inefficient local production. Drugs for which production could be geared up quickly in a crisis do not need to be stockpiled at all.

3.411 Review and Update Drugs Approved for Marketing

At the same time, it would be useful to conduct a review of drugs for which evidence of safety and effectiveness was never required and remove from the market those lacking such evidence. It may be possible to invoke the experience of countries which have already conducted such reviews and reduce the time and expense needed to conduct an independent survey.

Pharmaceutical Distribution

3.5 Impediments

There is no question that the following impediments to a well functioning , cost-effective pharmaceutic distribution system can best be resolved in the context of privatization. Among the most visible impediments in the distribution sector are these:

3.51 Monopolistic Control of Wholesale Distribution

Russia's drug distribution system includes approximately 80 wholesale operations which historically have had monopoly control of drug supply within their defined region. These "synthetic" monopolies have been reinforced by the difficulties local pharmacies face in purchasing drugs directly from producers or importers. Wholesale activities are characterized by low inventory turns, high administrative costs and low service levels.

This economic insufficiency is reflected in wholesale markups of 10-15 percent, and in some areas (*e.g.* Irkutsk and Vladivostok) markups are as high as 35 percent. Typical western markups are only 5-8 percent. These regional monopolies are starting to erode however, particularly around Moscow. There is no rule barring formation of wholesale operations. In fact new wholesale operations are being organized, some by foreign interests. The liveliest competition among wholesalers is in the Moscow area.

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3.52 Inefficient Distribution Methods

Recognizing the need to handle large numbers of small units, advanced drug distribution systems typically include product coding and automated methods of inventory, stocking and financial control. Understandably, these are generally lacking in Russia, contributing further to regional shortages, stock loss, delayed delivery, reduced turnover and high costs.

Transportation is another serious distribution problem. Because of the unreliability of delivery service, including pilferage, consignees typically feel constrained to take possession of drug purchases directly from distributors. Equally serious are difficulties in making payment for purchased pharmaceuticals, circumstances requiring bank-to-bank transfers which can take from days to weeks to accomplish. Communications problems with wholesalers are also cited by drug producers.

3.53 Economically Insecure Retail Distribution

While retail pharmacies are not numerous in relation to the Russian population (1 for each 9200 inhabitants in Russia versus 1 per 5000 in the United Kingdom and 1 per 2600 in France), they are only beginning to supply so-called "front-end" consumer products, such as cosmetics and convenience items, that compose a substantial proportion of pharmacy sales in most nations and contribute significantly to their profitability. Their limited sales compared to western pharmacies, which are in a much more competitive environment, also shows the relative weakness of the Russian retail distribution sector. Sales are typically $100 to 200,000 per pharmacy versus $500,000 to 100,000 in the West. The constraint on earning resulting from this lack of product diversity is compounded by economically

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inefficient reimbursement methods.

Currently, retail drugs are priced at a 50% markup on manufacturers' prices, reduced by a 10-15% (or as high as 35%) markup on manufacturers' prices for wholesale distribution. Given the 50% cap on distribution margins coupled with wholesaler inefficiencies, pharmacies' profits are close to zero, even with municipal privileges like low rent. As these privileges disappear, the need to increase pharmacies' margins, to ensure financial viability, will become more important.

3.54 Inhospitable Economic and Policy Environment

As with the manufacturing sector, these structural problems are multiplied by the difficult economic and policy environment in which drug distributors must conduct business. High levels of receivables, rampant inflation and the unavailability if credit are problems which, while not specific to this sector, nonetheless affect it tremendously.

3.55 Emerging Legal Structure

As in the manufacturing sector, there is perhaps no greater deterrent to privatization and foreign investment than the lack of a consistent legal structure to undergird the formation of private enterprise. Recent legislation described later in this paper demonstrates the Russian government's determination to address these concerns.

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3.6 Considerations for Optimal Privatization

In our judgement, adoption of the following measures would provide a practical and workable framework as well as incentives needed to attract investment in a progressively privatized pharmaceutical distribution system.

3.61 Develop a Competitive Distribution System

Some officials of western firms based in Russia cite the distribution system as perhaps the single most pervasive block to an effective pharmaceutical sector. While in some areas regional monopolies still control the distribution of pharmaceuticals, new competition is emerging in more heavily populated areas. The privatization of Russian pharmaceutical manufacturers would be of limited value if those producers lack access to an efficient wholesale distribution system. To aid the creation of a more efficient distribution system, individual wholesalers need to improve stock turns and service levels, invest in electronic data processing systems and necessary sanitary conditions, and reduce personnel. Government policy should encourage the development of a private, competitive national distribution network. We believe the government should encourage further competition and investment in this vital area, requiring as a condition of license that the wholesaler carry a full line of needed therapeutic agents, at least those included on what should emerge as a meaningful essential drugs list.

While it might prove difficult because of strong local control, it is also worthwhile to consider the possibility of bundling geographically dispersed wholesalers with the aim of creating privatized national wholesale corporations. Administering or managing such a

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transition could prove difficult. Having as few restrictions as possible, *i.e.* freely granting wholesale licenses, is a way to achieve a competitive and efficient distribution system. It will in any case probably be faster, especially if foreign distribution groups are invited to apply for licenses.

In Russia, over one hundred wholesalers have monopolies in regional markets. They do not compete against each other on a national level. Most countries have few wholesalers which compete for distribution in the entire national market, and this pattern is emerging in other formerly socialist countries. For example, as a member of the former Soviet Bloc, Hungary had a distribution system similar to Russia's.

Hungary attempted to reform its pharmaceutical distribution system by "bundling" together different wholesalers into four to five national wholesale companies, improving both the level of competition and service. Hungary's method of privatization was to pre-structure a few national of supranational players by bundling regional wholesalers at the time of privatization. This method requires nonadjacent regions to ensure overall national or multinational coverage. The size of the regional clusters or constitutive elements of these national wholesalers should be sufficient to enable local restructuring if needed.

Another option is to privatize individually the regional monopolies and let market forces act to produce the needed restructuring. This will probably led to competition from greenfield operations in the neighboring regions, and/or purchase of regional entities by others. A number of mergers or bankruptcies are likely to occur.

Although the first option, of bundling national wholesalers, has the advantage of leading

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rapidly to a competitive and efficient national distribution system, it would in practice be very hard to implement in current circumstances in Russia, particularly given the importance of *oblast* decision-makers in regard to wholesalers. The second option, of opening up the market to competition, is probably the most attractive for new entrants, particularly foreign distribution groups. The transition towards an efficient and competitive distribution system can be brutal under the second option, as the existing regional wholesale structures are exposed to greenfield competitors. It will probably mean bankruptcy of a number of the newly privatized regional wholesalers.

To ensure a continued supply of drugs to different regions, the government could oblige wholesalers to carry a list of essential drugs and to regulate wholesale margins -- including transportation costs to serve different parts of the country.

More competitive markets do serve to lower wholesaler margins. In areas of Russia with greater competition, like St. Petersburg or Moscow, margins are five percent. Remote areas with little competition, like Irkutsk, have wholesaler margins of up to thirty-five percent. To prevent monopolistic abuse in ares with little competition, most governments put in place maximum wholesale margins of about 15 percent. Given the importance of government reimbursement for a significant part of drug purchases/consumption, maximum margin caps serve to control government expenditures on the drug budget.

3.62 Reform Retail Pharmacy Operations

Retail pharmacies ought not to be given the continuing incentive to dispense high cost products where less expensive alternatives are available. Reimbursement on the basis of a

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uniform negotiated dispensing fee would reduce that incentive. Most OECD countries regulate pharmacies' margins. This is generally achieved through digressive percentage markups, or through a flat dispensing fee. The 50 percent markup needs to be amended or abolished to ensure the profitability of pharmacies. While the state could eliminate all margin controls, the continued role of the state in funding drug purchases requires the continuation of some margin controls.

Like wholesale operations, retail pharmacies, singly or in groups, should be attractive for privatization. In some countries, ownership of pharmacies is limited to pharmacists. Such a restriction would create a class of small professional owners, might keep the disruption of supply during the transition to a minimum, and it would offer some protection to individual pharmacies. Nonetheless, restricting ownership would simply inhibit beneficial competition.

The number of pharmacists is too small to base the entire pharmacy privatization project on their involvement. In any event, it is likely that individual pharmacies would predominate for some time before the possible emergence of western-style chain operations. While chains of pharmacies are unlikely to spring up any time soon, the number of pharmacies is likely to double over the next several years. Licensing and other regulations in Russia should be liberal to permit this process to occur.

Another important issue in pharmacy privatization is what kind of product line pharmacies should carry. Because there are so few pharmacies, a general list of drugs that individual pharmacies are required to carry seems reasonable. Beyond the requirement to carry essential drug, a liberal approach to allow pharmacies to sell a range of other products, like herbal medicines, cosmetics and hygiene products, would be desirable in order to improve

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the profitability of privatized pharmacies. The expansion of product line will bring with it a concomitant need for sophisticated computer information systems to handle the product complexity. A profitable privatized pharmaceutical sector will best be able to afford these investments in the future.

Sources of further gains in profitability probably lie in the gradual reduction of over staffing. For instance, a pharmacy in Moscow, with four kiosks, generating overall sales of $750,000, employed 28 people, versus four or five people for a comparable pharmacy in the West. The differences in staff levels also reflect the lack of sophisticated computerized information systems in most Russian pharmacies.

3.63 Develop Training and Expertise

Although some pharmacy directors and warehouse managers are prepared to tale on the role of a private entrepreneur or manager, these skills need to be nurtured and developed. Substantial training and support will be needed to private sector methods and demands.

3.7 Financing of the Pharmaceutical Industry

The current control system needs to be changed. Producers are now allowed a 30 percent markup over costs, (*i.e.*, the interest paid on borrowed credit and some labor costs). In addition the costs of raw materials must often be paid in advance, whereas payments for finished products arrive much later. Given present inflation levels, profitability is problematic at best. Even beyond inflation, a cost-plus pricing systems ends all the wrong signals to current and potential investors. There is no incentive to improve efficiency

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because costs can simply be passed on to consumers. Moreover, the 30 percent cap limits the amount of profit available for reinvestment in dire need of restructuring. We recommend eliminating the margin cap, and allowing market forces to set appropriate producer prices.

Wholesalers and retailers have similar limits to what they can markup, although survey information tends to indicate that adherence to the wholesaler and retailer price caps varies markedly from region to region. Economically, these artificial price controls have the same adverse business consequences at the wholesale and retail levels as do the markup caps in manufacturing.

Paying for pharmaceuticals at the consumer level remains a major issue. Under the new health insurance legislation, pharmaceuticals are not expressly covered, although they are not excluded. In drafting new legislation, we recommend that consideration be given to covering pharmaceuticals from both the compulsory and voluntary health insurance funds, thus increasing the likelihood that adequate financial resources would be available.

It would be most efficient to make reimbursements at the consumer level perhaps differentially based on the therapeutic importance of specific classes of drugs, and eliminate subsidies at the manufacturers' level, the latter simply protecting production inefficiencies. Given the experience in western countries, we believe the distortions introduced by complete reimbursement of medical costs through insurance companies can and should be avoided. It would be important to encourage competition by not limiting reimbursement to domestically produced drugs. These changes will provide more market-oriented financial systems, and will be a substantial incentive in attracting foreign investment at all levels.

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Increased government reimbursement would provide a stimulus to consumers, and therefore to producers -- both domestic and foreign. No explicit rationing mechanism for reimbursement cost containment is currently in place. Western experience suggest three option for reimbursement cost rationing:

- Via the purchasing power of large buyers with no explicit government interference (HMO system in the U.S.).
- Reference price system, in which only a fixed percentage of the least expensive appropriate drug is reimbursed.
- Price caps, where a reimbursement cap is set directly for certain types of drugs.
- Any of the above options would be better than the current reimbursement scheme. However, the reference price system could be recommended as the preferred option. It combines flexibility, objectivity and effectiveness in cost containment. Price caps may be considered as the second best option. It is less flexible and objective and can lead to bureaucratic inefficiencies. If the price is set too low, caps may drive certain drugs out of the market.
- Tariffs on pharmaceutical are another important financing issue. At present, Russia appears to be duplicating Poland's ill-advised policy of allowing tariff-free imports of finished forms, while imposing tariffs on finished substances. Not only does such a policy fail to protect local producers, but it actively discriminates against them. Tariffs on active substance imports -- as well as tariffs on production equipment -- should be eliminated. By the same token, requirements for the domestic production of strategic drugs (however defined; this is itself a highly problematic question) should be held to an absolute minimum. Such production would undoubtably have to subsidized by the government, thus absorbing scarce resources and further distorting market pricing patterns.

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Section IV

Legal Framework

4.1 Legislative Foundation

A number of overlapping pieces of legislation and Presidential Decrees already exist to provide legal guidance for the Russian Federation's privatization program. The most important here are:

- Law of the "RSFSR on Privatization of State and Municipal Enterprises in the RSFSR," dated 3 July 1991; as amended by the Law of the Russian Federation on "Amendments and Additions to the Law of the RSFSR on Privatization of State and Municipal Enterprises in the RSFSR," dated 5 June 1992;
- State Program of Privatization of State and Municipal Enterprises in the Russian Federation, adopted by the Supreme Soviet of the Russian Federation on 11 June 1992, as subsequently amended;
- Law of the RSFSR on "Foreign Investments in the RSFSR," No. 1534, dated 4 July 1991; and
- Decree of the President of the Russian Federation on the State Program of Privatization of State and Municipal Enterprises in the Russian Federation, No. 2284, of 24 December 1993.

The most directly pertinent here is the last, hereinafter referred to as the "Presidential Decree on Privatization of 1993" (or, the "Decree"). This Decree provides that by 1 March 1994, the

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Council of Ministers of the Government of the Russian Federation (hereinafter, the "Council of Ministers") prepare draft laws of the Russian Federation "On the Privatization of Public Health Institutions and Pharmaceutical Institutions and Enterprises." (Decree, Preamble, Sec. 2, Para. 5). The Decree also provides that by 25 January 1994, the Council of Ministers shall prepare "appropriate changes" to current Russian Federation tax legislation. (Decree, Preamble, Sec. 2, Para. 9) Section 2 of the Decree specifies deadlines for several other changes in the authorities set out above, many of which have already not been provided by the deadlines set out in the Decree.

Consistent with the Decree, the State Program on Privatization of State and Municipal Enterprises in the Russian Federation (hereinafter referred to as the "State Program") seeks, *inter allia:*

- To form a broad strategy of private owners as an economic basis for market relations;...
- To complete privatization of the majority of the objects of 'small privatization' and, on the basis of this, to accelerate the development of the commerce and service spheres;
- To fulfill, for the most part, privatization of large and medium-scale enterprises of industry and constructions;... and
- Public health institutions and enterprises, and also pharmaceutical institutions, pending the passage of a law or other legislative aspects of the Russian Federation, shall be privatized by a special procedure established by the Government of the Russian Federation. (Decree, Title 1, Paras. 5, 8, 9, and 21)

The Presidential Decree on Privatization of 1993 provides four broad classifications of Federal "Objects and Enterprises Based on the Possibility of Privatization Thereof."

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(Decree, Title II) These are: (1) enterprises prohibited from privatization (Decree, Title II, Sec 1); (2) enterprises permitted to be privatized only by a decision of the Government of the Russian Federation (Decree, Title II, Sec. 4); (3) enterprises permitted to be privatized only by a decision of the GKI of Russia[1], taking into account the opinions of sectoral ministries and departments (Decree, Title II, Sec. 3); and (4) enterprises permitted to be privatized by state and municipal governments and other local governments. (Decree, Title II, Sec. 4)

The process of denationalization and privatization in the health sector, which the proposed legislation should promote, needs to be consistent with the principles of the Health Insurance Legislation signed by the President on April 16, 1993. The proposed denationalization and privatization legislation also needs to reflect the uniqueness of the sector and the social and political sensitivity associated with medical care. Consequently, the legitimate concerns of the medical profession, the Ministry of Health and regional health authorities need to be carefully considered.

In the health-care sector, a summary of how these institutions break down is as follows:

- Hospitals: to be privatized by procedures established by the Government of the Russian Federation;
- University Health Care Facilities and Hospitals: to be privatized by procedures established by the Government of the Russian Federation, although certain advanced medical training centers are prohibited from privatization;

[1] GKI is the "State Committee of the Russian Federation for the Management of State Property. Its authorities were established in Article 4 of the 1991 Privatization Law. GKI is responsible for ensuring "that a uniform state policy of privacy is maintained...." (Article 4, Sec. 2), and has overall responsibility for drafting the State Program for Privatization.

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- Polyclinics: to be privatized by procedures established by the Government of the Russian Federation;
- Scientific Research Institutes: prohibited from privatization;
- Orphanages, Nurseries, Homes for the Elderly: prohibited from privatization;
- Medical Equipment Manufacturers: Permitted to be privatized, except for certain enterprises involved in the production of prosthetics;
- Pharmaceutical Producers: permitted to be privatized, except for manufactures producing narcotic drugs legally, and which process crops bearing narcotic substances;
- Pharmaceutical and Medical Supply Wholesalers: permitted to be privatized except those wholesalers which distribute narcotic substances, and only by decision of the Government of the Russian Federation;
- Distributors and Wholesalers: permitted to be privatized only by decision of the Government of the Russian Federation; and
- Pharmacies: to be privatized by procedures established by the Government of the Russian Federation.
- The Law of the Russian Federation on Health Insurance of the Citizens of the Russian Federation of 1991, as amended in 1993, could also play a major role in a privatized health-care system. The insurance program is in two forms: compulsory and voluntary. "Compulsory health insurance is part of the state social insurance, and provides equal abilities for all citizens . . . in obtaining medical care, which is funded through compulsory medical insurance funds.... Voluntary health insurance is carried out on the basis of Programs of Voluntary Health Insurance, and provides the population with any medical and other services not covered.... " by compulsory insurance. (Chapter 1, Article 1).

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Interestingly, the statute explicitly states, however, that "health insurance companies are not part of the health care system. (Chapter 3, Article 14) The Chapter further states explicitly that Government bodies supervising the health care system and medical facilities cannot set up health insurance companies." (Id.) Paradoxically, however, such government bodies may own shares of health insurance companies not exceeding ten percent of their capital funds. (Id.) The statute makes no explicit reference to the handling of pharmaceutical products.

Both the compulsory and voluntary stages of health insurance are in their infancy, and much remains to be seen about how they will actually operate, and at what cost. The Russian health insurance law ("HIL"), with the health finance system, stipulates far-reaching changes in the organization and management of the health care sector.

This legislation falls conceptually in line with the systematic reforms that have been taking place on other developed economies. The adoption of a new law was an important step in moving the Russian health sector toward non-governmental organization, management and provision of services -- thus increasing the quality of care and service -- while retaining public control at a decentralized level over finance in an attempt to maintain the solidarity principle which guarantees, at least in theory, a basic package of care to every Russian citizen. Implementation of the HIL appears to be taking place with wide regional variations.

The HIL would effectively allow separation of (a) the funding of care in Russia, (b) the organization and management of care for consumers by "insurance companies" or sickness funds wherever possible, and (c) the provision of care. The HIL legislation aims to offer Russian citizens two levels of choice. The first is the right to enroll in any insurance company or sickness fund they wish, without going through an employer. The second level

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of choice is among alternative competing care providers. The HIL envisions non-governmental competing "insurers" as well as providers of care. The proposed denationalization and privatization legislation should promote these institutions, moving structures from their current status to a reformed system in line with other modern health systems. Consequently the HIL stipulates the following institutions:

- Federal and Regional (Social) Health Insurance Funds ("FHIF" and "RHIF"). The central institutional feature of the amended law could be the creation of separate, social, compulsory health insurance ("CHI") funds at the federal and territorial levels for the management of compulsory insurance revenues from a wage-bill tax and federal and territorial governments' contributions. The funds are to be established as independent non-commercial finance and credit institutions. The federal CHI fund is given the function of achieving cross regional equity objectives.
- Health "Insurers." Fund managers would contract with insurers or sickness funds for the management of care for their constituent or enrolled populations. Where such insurers were not available (1993), branches of territorial CHI funds would assume their functions. The insurers (and by implication the territorial branches) would be reimbursed under a contract capitation basis. An important aspect of the HIL is that it would allow insurers to perform the functions of care mangers and providers either by using salaried personnel in their own medical institutions or, as stipulated by the HIL, by buying services from independent providers of care. These insurers could thus become HMO-type institutions.
- Private Insurers. Alternatively, private insurance firms could be encouraged to avoid the bureaucratic inefficiency of government managed operations. Such firms presently exist, but their ability to grow -- and thus lower insurance costs because of increased

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risk spreading-- is inhibited by uncertainty over the future of financing mechanisms.

- Providers of Care. Provision of care under the HIL is handled through hospitals, polyclinics, solo practices, pharmacies (for their part in supplying pharmaceuticals) and by a variety of institutions providing all kinds of services (laboratory, imaging, specialized treatment among others).

4.2 The Process of Privatization

Within these broad outlines, obviously several models are available, and we shall consider those appropriate for the different kinds and sizes of health-care enterprises. Nonetheless, although the process of privatization in Russia is still in its early stages, a pattern for implementing that process has emerged. We believe that adhering to that process in the health-care sector will facilitate the rapid and efficient privatization of health-care organizations at both the national and local levels.

4.21 Valuation of Assets

The first step is the valuation of assets to be privatized, pursuant to Addendum No. 2 to GKI's Provisional Regulations of 1992 on that subject, as they may be amended. Valuation is important both for determining an enterprise's initial price for sale, but also to determine the level of authorized capitalization of the joint-stock company. This step requires a full inventory of fixed assets, intangible assets (such as rights to intellectual property, and long-term investments) and financial assets. Liabilities -- depreciation, accounts payable and long-term loans -- are then deducted to obtain the net asset value. The pertinent standing commission on privatization would then issue a certificate of valuation, and the management

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of the state or municipal enterprise being privatized would be required to preserve the assets of the entity pending the actual transfer of ownership.

The asset preservation feature is especially important to potential foreign investors when sensitive intellectual property rights may be at risk during a transition. Moreover, the issue of inflation between the time of valuation and the time of the potential sale -- not addressed in the GKI regulations and presently a serious problem -- must be resolved. New legal standards on the inflation issue must be developed, perhaps using dollars or an international basket of currencies, because financial uncertainty will certainly deter foreign trade or investment.

In line with other developed health care systems, the Russian HIL allows for competing insurers and providers, but is flexible with regard to the ownership of these institutions. The legislation to be proposed by GKI needs to consider carefully the different types of ownership possible for the different types of institution according to type of care and location. Both private and public finance should be used in the reformed health care system.

4.22 Developing Applications for Privatization

The second step is developing applications for privatization, pursuant to Addendum No. 1 to the GKI's Provisional Regulations of 1992, as they may be amended. Such applications are to be filed with the district or city Committee for the Management of State Property, and the GKI local agency near where the enterprise is located. The local GKI's would be required to accept or reject any application, passing those accepted on the local commission on privatization. The commission, in turn, would draw up an operational plan to accomplish

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privatization, and return it to the GKI. Since this procedure could be somewhat cumbersome, strict adherence to tight time lines in processing applications is essential. Otherwise, both the transaction costs and "political" concerns of applicants would rise, and the applicants might withdraw to seek greater efficiency, certainty and profits.

State owned monopolies dominate the Russian health scene today. Some of these institutions are mainly associated with national research centers and are not subject to privatization under the 1993 Decree. Other institutions could be encouraged to privatize through striking a balance between the incentive of investors to invest and the welfare of the population they serve. Still others need to be broken up in the process of denationalization and privatization.

4.23 Bidding and Sales Process

The third step is the bidding and sales process, to determine who will actually own the privatized enterprise, once sold. The bidding process is open to entities and persons who have submitted the approved applications described above, and there are some advantages created in certain circumstances for the existing work forces of state and municipally owned enterprises. Technically, the sales process involves "auctions" and two types of "tenders."

The procedural and substantive distinctions between these methods may have considerable importance in privatizing the health-care industry. Much depends, however. on the underlying policy motivating the extent and pace of privatization decisions, as the following discussion demonstrates.

The standard "auction" involves a transaction under which the property sold simply goes to

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the highest bidder in an open bidding process. By contrast, following the "commercial tender" procedure (conducted pursuant to Addendum No. 4 to the GKI's 1992 provisional regulations), requires that the buyer must be the highest Russian or foreign bidder, who is required to pay a bid deposit of ten percent of the estimated total price, and meet certain other procedural requirements. Finally, there is the "investment tender," under which a bidding commission in effect represents the seller and evaluates the bids on more than financial considerations. Addendum No. 5 to the GKI's regulations provides that additional "suitability" factors such as employment guarantees, investment commitments, social provisions or other considerations may be among the issues raised during an investment tender.

"Auctions" and "commercial tenders" are fundamentally based on the same concept. Auctions are typically most suitable for small enterprises -- retail outlets such as pharmacies, polyclinics and medical practices, and are also usually the fastest and least-complicated way to consummate a transaction. Commercial tenders can be suitable for small enterprises, but they are also appropriate to spin off medium-sized enterprises such as some pharmaceutical wholesalers. Investment tenders tend to be appropriate vehicles for the disposition of the largest industries because of the greater likelihood of obtaining so-called "strategic partners," and because the government is entitled to impose conditions which may be deemed necessary for economic or social reasons. Nonetheless, we would recommend no hard-and-fast rules for privatization transactions in the health-care industry, but rather utilizing the various sales methods appropriate on a case-by case basis.

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4.24 Transformation into Joint Stock

The fourth step is the transformation into joint stock status of state and municipally owned enterprises, pursuant to Addendum No. 3 of the GKI's 1992 provisional regulations, as they may be amended. The relevant Committee for the Management of State Property would create the privatized company pursuant to the approved privatization plan, and file a registration request and articles of incorporation with the local body in charge of official representation. Upon registration. the state or municipal enterprise shall be considered a joint-stock company and the assets transferred to the new company's books. The new company will be the legal successor of the earlier enterprise, with all of its rights and liabilities.

In general, franchising should be encouraged by the denationalization and privatization legislation as a lever to promote privatization and competition across the country. Investors should be offered "bundles" of institutions, including lucrative facilities, in urban centers, as well as facilities in areas that otherwise would not be attractive to investors. The privatization process should avoid creating a situation whereby outlying and socially and economically weak areas cannot benefit from privatization.

4.25 Privatization Funds

Finally, consideration should be given to privatization funds created by the employees of state and municipally owned enterprises, pursuant to Addendum No. 6 to the GKI's 1992 provisional regulations, as they may be amended. These funds provide a method for employees to build up assets by which they could ultimately be used for the employees to

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bid for equity interests when their employers are privatized. There are certain restrictions to contributions to privatization funds to avoid diverting the assets of the firm (or proceeds from the sale of assets) into the funds.

4.3 Legal Considerations for Optimal Privatization

To accomplish privatization in the health-care sector, a number of different models may be considered. As earlier sections of this Report have indicated, the varying conditions of the sectors involving the provision of medical care and pharmaceuticals may well indicate alternative ownership solutions. We consider issues of subsidies and price controls in the next section, fully recognizing that these issues often overlap. We also understand the traditional health-and-safety regulatory framework that surrounds every health-care system worldwide, as discussed above. Nonetheless, we believe that, in any market-driven system, the legal issues surrounding private ownership are fundamental, and we therefore address them first.

4.31 Pharmaceutical Manufacturing

In the field of pharmaceutical manufacturing, we see no reason why straightforward ownership by entirely privately-owned joint-stock companies is not justified. This model has been fully satisfactory in the U.S. and other OECD countries. and there is no economic, political or legal reason to believe that it cannot succeed in a privatized Russian economy as well. Private ownership by partnerships or even individuals is also possible, assuming adequate economic resources to make the purchase at the time of privatization or thereafter.

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Assuming full opportunity for foreign investment in this sector, moreover, we see no monopolization problems that cannot be handled by generally applicable antitrust standards. Pharmaceutical manufacturing appears to be particularly attractive for securing "strategic partners" worldwide, who will have significant economic interests in restructuring the firms to make them more competitive and cost-efficient.

4.32 Pharmaceutical Wholesaling

Pharmaceutical wholesaling can also be handled by the same private ownership mechanisms. Here, however, we see greater potential antitrust problems if privatization is not carefully handled. Because of the existing structure of regionally-restricted distribution facilities, usually through "pharmacies" on an oblast-by-oblast basis, a simple transfer of the assets of existing enterprises to privately-owned companies could result in a series of sub-national wholesale monopolies. This result would be completely unacceptable.

Obviously, privatization and demonopolization should go hand in hand, and we therefore recommend that options other than simple privatization of the approximately 80 pharmaceutical distributorships be required. For example, the enabling legislation for privatization could require that several wholesalers in different areas be privatized as a group. Such an approach could lead to eight-to ten nation-wide wholesalers. Another demonopolized alternative would be a series of subnational wholesalers, which would be geographically competitive.

Conceptually, either model appears acceptable. It is critical beyond dispute, however, that whichever model is chosen, there must be no territorial restrictions or limitations on

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privatized wholesalers to compete. Otherwise, geographical monopsonies/monopolies at the wholesale level could frustrate the entire privatization program. We believe that market forces will ultimately determine the optimal structure of the Russian pharmaceutical wholesaling structure, so the important starting point is to prevent private monopolization (nationally or locally) at the opening stages.

4.33 Pharmaceutical Retailing

At the level of pharmaceutical retailing. we believe again that entire privatization is appropriate. There is simply no justification for continued governmental involvement in any retailing business, and pharmaceuticals are no exception. Nonetheless, in order to enhance the viability of retail pharmacies, we believe that enabling legislation should make clear that "pharmacies," however denominated, are also entirely free to sell non-pharmaceutical products. Such a possibility for diversity of sales would mitigate against sharp swings in pharmaceutical availability and prices, and also provide useful incomes for pharmacy owners.

Similarly, while we believe that those actually charged with dispensing pharmaceutical products should be licensed to do so by appropriate authorities, we see no reason that ownership of pharmacies should be subject to any medical licensing requirements. Ownership should be open to anyone with sufficient purchasing power, willing to abide by a commitment to deal only in lawful pharmaceuticals, through licensed dispensers.

We recognize that there are some remote and rural areas where the present or even future availability of pharmaceuticals is limited. These same areas undoubtedly suffer from

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shortages of other critical commodities, and their particular needs may need special attention in the enabling legislation. We do not believe, however, that these relatively few problems should skew the privatization policy of the entire sector of retail pharmaceuticals. We also recognize that there will be unemployment caused by the necessary restructuring in the pharmaceutical industry, and we believe that attending to this misfortune should be the burden of society as a whole rather than the industry itself.

4.34 Hospitals

The privatization of hospitals is somewhat more complex. Even in most OECD countries, there has been a long tradition of government ownership of hospital facilities, whether at the national or local level. Nonetheless, there is also an extensive record of hospital ownership by not-for-profit institutions and conceptually analogous entities, and an increasing and impressive record -- especially in the U.S. -- of hospital ownership by for-profit companies. Hospitals require unique considerations that have equal importance in both the economic and legal realms; consequently we reiterate here in detail the privatization approaches found in Section II.

We recommend, therefore, a range of options for privatizing hospitals and related facilities. First, we believe that straightforward private ownership be permitted by the enabling legislation. Despite the emotional implications often associated with health care, it is a service fully capable of being supplied by privately-owned firms, often at a lower cost to consumers. Moreover, for-profit hospitals owned by chains have an impressive record in the U.S. of achieving economies of scale, which "singly-owned" hospitals would find impossible to achieve.

Second, we believe that legislation to create a not-for-profit, "charitable" hospital model should also be created. These could be "owned" by civic charities, labor unions, religious orders, fraternal societies, academic institutions, and similar organizations. Examples of implementing legislation for such ownership forms are widespread, and easily adopted to the Russian environment.

Other analogous. legal forms, such as the quasi-nongovernmental Self Governing Hospital Trust ("SGHT") model in the United Kingdom and the legal structures and experiences for hospitals in Israel and Scandinavia are also available. In all of these cases, as with for-profit hospitals, the operation depends on fees for services, with no governmental budget to rely upon. The Russian Territorial Medical Associations mentioned above are similar to these international models.

Third, we understand the likelihood that municipal-level ownership of hospitals will remain highly prevalent in the near future. Accordingly, we recommend that the legal form of municipal corporations be expanded or created to include medical facilities. We further recommend that the officers and boards of directors of municipal hospital corporations be shielded from political influences, and that they be permitted to function on as economically viable basis as possible. Where the pertinent municipal government chooses to provide medical services as a local charity, we recommend that these services be implemented on a contractual basis between the hospital and the municipality, with all services fully reimbursed.

For all hospitals owned by not-for-profit organizations, municipalities, or retained by the government, we strongly recommend that the enabling legislation permit the contracting-out

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of services to private organizations. Such contracting out would minimize inefficiency, and permit a more business-like atmosphere to enhance the provision of care and keep costs down, thus benefiting consumers. There has been world-wide success, for example, with privatizing hospital management, frequently using firms which themselves own private hospitals. Similarly, food services, laundry and linen services, equipment supply, and specialized medical services such as radiologists, anesthesiologists and X-ray technicians, can be supplied by private firms to not-for profit and government owned hospitals.

Moreover, it is also critical that implementing legislation not discriminate among hospitals because of their type of ownership. Non-governmental hospitals should have the same access to patients, physicians and medical resources as governmental facilities. Any other treatment would create a non-level playing field, and deprive health-care consumers of the treatment and financial benefits of competition.

4.35 Polyclinics

Polyclinics produce fewer conceptual legal and economic problems for privatization. Based on the experience of virtually all OECD countries, the private provision of primary health care should be the fundamental basis of national health services for most citizens. The model of "professional corporations" (even for sole practitioners) provides a basis for limited liability (except for medical malpractice claims and the like) that should afford sufficient economic protection for physicians and their assistants. Obviously, the traditional partnership model also remains available, so that, under either legal formulation, the physicians of polyclinics could remain associated together or pursue their separate practices as they saw fit.

4.4 Legal Prerequisites to Privatization

Perhaps the most pervasive economic aspect of the Russian health-care system -- other than government ownership -- is the complex system of cost controls and financial subsidies which pervade the entire system. Indeed, it is nearly impossible to obtain adequate information on the extent of subsidies, and the price controls are as often ignored in the breach as they are observed.

In the pharmaceutical industry, for example, wholesalers and retailers are presently limited in the markups they are allowed, meaning that at both levels they fail to achieve profitability, thus requiring governmental (usually municipal) subsidies. Polyclinics are actually forbidden even to charge for services, although that restriction has already begun to erode in practice. These same polyclinics, however, receive below-market rental rates for their facilities. The result is an economic and legal morass that impairs the delivery of effective health care services.

This system of subsidies and cost controls infects both the entire pharmaceutical industry and the structure of hospitals and polyclinics. There is no question that eliminating this system will cause disruptions, inconveniences and temporary shortages. Obviously, this is true for every sector of the economy, as are the problems of inflation and the unavailability of credit. Nonetheless, we believe that both the system of price controls and financial subsidies should be eliminated immediately upon privatization, or as soon as possible thereafter, if not before. Otherwise, it will simply not be possible to benefit fully from the privatization program.

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4.5 Protecting Intellectual Property

As noted above, the business and financial implications of protecting intellectual property rights are critical both to a growing domestic Russian economy and to foreign investment. It is simply not credible to believe that pharmaceutical manufacturers, for example, which typically invest extremely large amounts of financial and human resources in research and development, and require years to reap a return on their investments will risk losing these investments in an economy which does not respect and enforce the concept and rights of intellectual property.

The Law of the Russian Federation on "Foreign Investments in the RSFSR," No. 1534, dated 7 April 1991, noted above (hereinafter, "Foreign Investments Law") appears to recognize the importance of intellectual property rights. For example, the Law provides explicitly that "foreign investments" include "intellectual values" as well as other materials placed in Russia to derive profits or income. Foreign Investments Law. Article 2). Moreover, Article 32 of the Foreign Investments Law states that:

The protection and execution of rights to the intellectual property of enterprises with foreign investments shall be guaranteed in accordance with the legislation in force on RSFSR territory. Enterprises with foreign investments shall conclude with their employees contracts in regard to the rights to objects of intellectual property created in keeping with the assignments confirmed by the enterprises' documents.

Finally, the Foreign Investments Law also provides generally that "In cases of nationalization or requisition, the foreign investor shall be paid prompt, adequate and effective compensation. "(Chapter II, Article 7, Sec. 1)

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Thus, at least in theory, the rights of foreign investors to the protection of intellectual property rights is at least as great as that of Russians themselves. Legally, therefore, there does not seem to be additional authority required, although a more detailed elaboration of patent, trademark and copyright protections would obviously be desirable. The intellectual property laws of almost any OECD country could serve as a model.

The real issue for the GKI and the government of the Russian Federation as a whole, is the political question of the enforceability of intellectual property rights. More than just the legal form of protection is required, especially for pharmaceutical products. Enforcement is essential. Accordingly, any steps toward privatization in the health-care sector must not only acknowledge the importance of private property rights, but permit mechanisms for their aggressive enforcement as well.

Section V

The Role of Public Education

A public education campaign is required to ensure success of the privatization of the health-care industry. Although a successfully privatized health-care system will ultimately provide higher quality care at a lower cost to the country, this is not readily apparent to all Russian people. Russia's socialist experience has left a residual fear and misunderstanding of privatization. This fear and misunderstanding become more powerful when the industry being privatized provides life saving services. Enhancing the public's knowledge about the transition programs is essential.

The best place to spend more money is at the primary level and in health education, prevention and screening. The clearest lesson from the West is that the most cost effective way to achieve high standards of health while containing costs is to devote more resources to primary care. It is important that a public education campaign accompany the health reforms, in order to explain and prepare the public and health care workers for these vast reforms. The public awareness campaign also needs to include health care providers themselves, some of whom may not understand the privatization process itself and work against it from fear of losing their jobs.

Moving toward non-government institutions, the possible use of "trusts" and other elements of the privatization program may be perceived as threatening to various constituencies. A primary objective of the campaign would be to build public support for changes by increasing knowledge about the process and by educating the public about how the increased

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availability of privatized medical care will result in a better quality of care in Russia. This campaign will provide a vital foundation for privatization of health-sector enterprises by creating the public support and understanding that must accompany the transformation of these industries.

Another reason why a public education campaign is needed is that there are public misperceptions that privatization and other activities leading to a market economy have left the Russian people worse off than the previous system while also threatening vested interests. Opponents of privatization claim that privatization threatens the social and economic fabric of the nation. Because of the sensitivity of health-care, public support for privatization of the health industry has significant political implications and must be garnered before programs are implemented

A public education campaign, then, must address several fundamental concerns of the Russian people. The campaign should:

a) Provide information about the activities being undertaken to assure the public that privatization will result in less-costly and better-quality coverage and increased availability of drugs;

b) Build confidence among various key constituencies about the efficacy of the privatization program, to ensure that the changes are perceived as successful and in the interests of the Russian people;

c) Build grassroots support for the privatization efforts;

d) Educate the public about the provisions in the program that guarantee a basic health-care package for all citizens;

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e) Serve as a catalyst for institution-building activities within the various disciplines to ensure economies of scale and cost effectiveness.

We envision that each element of the health program will involve a public education component, coordinated from Moscow, but decentralized to have the greatest local impact. The efforts would be part of the overall pilot program and roll-out to test various methodologies and to ensure replicability and sustainability in the future.

Elements of the public education program include:

a) National public polling and use of focus groups to ensure that specific concerns of the general public are addressed in the development and execution of the program;

b) Journalist briefings to ensure in depth positive reporting of the efforts underway;

c) "Bottom up" approach to build local, grassroots support for health care reform, and explain how even poorer areas would benefit from private companies;

d) Creation of a Steering Committee made up of leaders in each of the subindustries to ensure that industry concerns are addressed;

e) Initiation of an Investor Program to provide support , information and attract investment:

f) Establish connections between U.S. health-care institutions and Russian counterparts to exchange technology and experiences;

g) Sponsorship of conferences and seminars at which the benefits of health care privatization are examined for those directly involved in the process;

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The program would be two-pronged: 1) a nation-wide effort to provide information and education in the health-care sector; and 2) a program focused on each privatization activity in the respective fields.

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Section VI

Conclusion

The foregoing report had defined some critical issues surrounding the privatization of the pharmaceutical and hospital sector (as well as associated services) of the Russian economy. We have identified the positive and negative elements of the present Russian system, considered the impediments to and benefits of privatization, provided extensive legal suggestions for the privatization process and suggested the elements of a public awareness campaign to explain the implications of changes in this vital and sensitive sector.

We believe that the suggestions provided in this report will be operationally helpful as AID and the government of Russia struggle with complex issues involved in privatization. In particular, we believe that privatization alone cannot completely ameliorate the health care sector. Other changes are necessary as well, in fields as diverse as tax law, financing and health-insurance structures and other matters.

Nonetheless, we believe that the interest of the government of Russia in pursuing a privatization program in the health care sector is worthwhile, despite the attendant difficulties. We hope that this report will be of material assistance in that effort.

APPENDIX

SUPPORTING LEGAL DOCUMENTS

Much of the Final Report on Phase I focuses on the legal framework of privatization. The following section provides relevant Russian legal documents for reference.

Section 1: Law of the "RSFSR on Privatization of State and Municipal Enterprises in the RSFSR," dated 3 July, 1991; as amended by the Law of the Russian Federation on "Amendments and Additions to the Law of the RSFSR," dated 5 June, 1992.

Section 2: State program of Privatization of State and Municipal Enterprises in the Russian Federation, adopted by the Supreme Soviet of the Russian Federation on 11 June 1992, as subsequently amended.

Section 3: Law of the RSFSR on "Foreign Investments in the RSFSR," No. 1534, dated 4 July, 1991.

Section 4: Decree of the President of the Russian Federation on the State Program of Privatization of State and Municipal Enterprises in the Russian Federation, No.2284, of 24 December, 1993.

Section 5: The Law of the Russian Federation on Health Insurance of the citizens of the Russian Federation.

Section 6: Basic Provisions of the Ordinance of the Council of Ministers, Government of the Russian Federation "On Measures for Enforcing RF Law "On Amendments and Additions to the RSFSR Law "On Medical Insurance of the Citizens in the RSFSR" (Dated October 11, 1993 No.1018).

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LAW OF THE RSFSR ON 'PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES IN THE RSFSR' DATED 3 JULY 1991; LAW OF THE RUSSIAN FEDERATION ON 'AMENDMENTS AND ADDITIONS TO THE LAW OF RSFSR ON PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES IN THE RSFSR' DATED 5 JUNE 1992

This Law establishes the organisational and legal framework for the transformation of arrangements concerning ownership of capital goods in the Russian Federation through the privatisation of state and municipal enterprises with the aim of forging an efficient market economy geared to meeting social needs.

CHAPTER I. GENERAL PROVISIONS

ARTICLE 1. DEFINITION OF PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES

Privatisation of state and municipal enterprises shall be understood to mean acquisition by individuals or joint-stock companies (partnerships) into their private ownership from the state and from local Councils of People's Deputies of enterprises, plants, production bays and other divisions of such enterprises detached to form independent enterprises; of equipment, buildings, structures, licences, patents and other tangible or intangible assets of enterprises (either existing or liquidated by agencies duly authorised to take such decisions on behalf of the proprietor); ownership interests (equities, shares) of the state and local Councils of People's Deputies in the capital of joint-stock companies (partnerships); and ownership interests (equities, shares), which belong to enterprises marked for privatisation, in the capital of other joint-stock companies (partnerships), joint ventures, commercial banks, associations, concerns, alliances and other associations of enterprises.

Privatisation of state and municipal enterprises shall hereinafter be understood to mean privatisation of all properties listed above.

ARTICLE 2. RUSSIAN FEDERATION LEGISLATION ON PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES

1. Russian Federation legislation on privatisation of state and municipal enterprises shall consist of the laws of the Russian Federation "On Ownership in the Russian Federation" and "on Enterprises and Entrepreneurial Activities", of this Law and of other legislative acts of the Russian Federation and of republics within the same, regulating privatisation.

2. Privatisation of ownership interests (equities, shares) belonging to the state and to local Councils of People's Deputies in the capital of joint-stock companies (partnerships) co-owned with foreign nationals or corporate bodies or with international organisations shall be regulated by this Law and by other legislative acts in force in the Russian Federation and in republics within the same, as well as by agreements with foreign states.

3. This Law does not regulate restitution of the property rights of owners, their heirs and successors in rights to enterprises that have been nationalised, confiscated or otherwise taken against their will to become property of the state.

4. Acquisition of state and municipal enterprises by foreign nationals or corporate bodies shall be regulated by this Law, by Russian Federation legislation on foreign investment and by other legislative acts in force in the Russian Federation and in republics within the same.

5. Privatisation of land and housing stock, as well as of social and cultural institutions and of assets that are part of the cultural or natural heritage, shall be regulated by other legislative acts in force in the Russian Federation and in republics making part thereof.

ARTICLE 3. STATE PRIVATISATION PROGRAMME

1. The aims, priorities and restrictions in privatisation in the Russian Federation shall be determined by a State Programme for Privatisation. The Programme shall be submitted by the Russian Federation Council of Ministers and approved by the Russian Federation Supreme Soviet at least a month before discussion of the first reading of the Law of the Russian Federation "on Republican Budget". The Programme shall be drawn up for the three coming years and consist of a target assignment for the current year and a forecast for the two years that follow.

2. The programme shall contain the following:

- list of facilities (groups of facilities) in state ownership that are marked for privatisation, and a substantiation of their choice;

- requirements with respect to local privatisation programme;

- tasks set to agencies of state power and management in privatisation of state-owned property;

- determination of the preferable ways and means of privatisation and forms of payment, as well as benefits to staff members of enterprises slated to be privatised;

- terms and conditions of crediting and the amounts of credit resources planned to be used for privatisation;

- amount of privatisation deposits to be distributed to the nationals of the Russian Federation within the period planned, and the amount of such deposit for each recipient;

- terms and conditions of using foreign investment in privatisation;

- estimate of receipts from privatisation in the said Period, and rates for distribution thereof among the Russian Federation republican budget, the budgets of republics within the Russian Federation, local budgets, non-budgetary funds, and for other purposes;

- procedures for mutual settlements between property funds at different levels, as well as for their settlements with appropriate budgets with respect to all kinds of payment facilities; and

- list, time-frames and procedures for formation, with receipts from privatisation, of target-oriented funds for investment in the socially and economically most backward regions of the Russian Federation, for restructuring of the national economy, for rehabilitation of the environment, or for other purposes.

3. The Programme shall determine the list of state-owned enterprises and of associations or divisions thereof that shall not be subject to privatisation. This list shall be agreed upon with republics making part of the Russian Federation, with regions, territories, autonomous regions, autonomous areas and the cities of Moscow and St. Petersburg and shall be annually endorsed by the Supreme Soviet of the Russian Federation.

The Programme may also include lists of facilities, the privatisation of which shall require authorisation from the Government of the Russian Federation and the State Committee of the Russian Federation for the Management of State Property. In privatisation of enterprises included in such lists, the Government of the Russian Federation and the State Committee of the Russian Federation for the Management of State Property shall have the right to take decisions on retention of controlling blocks of their shares in state ownership for a period of up to three years.

4. To regulate privatisation on a day-to-day basis, the Russian Federation Council of Ministers shall have the right to alter standards, the list of which shall be included in the State Programme for Privatisation, without approval by the Russian Federation Supreme Soviet.

5. As a follow-up on the State Programme for Privatisation, the Supreme Soviets of republics within the Russian Federation and local Councils of People's Deputies shall adopt republican and local privatisation programmes and norm-setting acts regulating procedures for fulfilment thereof. Such republican and local programmes may not impose additional restrictions on privatisation of state-owned and municipal enterprises other than within the limits and in accordance with procedures to be established by the State Programme for Privatisation.

ARTICLE 4. STATE COMMITTEE OF THE RUSSIAN FEDERATION FOR THE MANAGEMENT OF STATE PROPERTY

1. Privatisation of state-owned property shall be organised by the State Committee of the Russian Federation for the Management of State Property.

The chairman of State Committee of the Russian Federation for the Management of State Property shall be included in the Russian Federation Council of Ministers and shall hold the office of a Deputy Chairman of the Russian Federation Council of Ministers.

Acting jointly with the appropriate Councils of People's Deputies, State Committee of the Russian Federation for the Management of State Property shall set up its territorial agencies, and determine their terms of reference, in republics within the Russian Federation, in regions, territories, autonomous regions, autonomous areas, the cities of Moscow and Leningrad and in other cities with a population of more than one million people.

The activities of the State Committee of the Russian Federation for the Management of State Property shall be financed out of the Russian Federation republican budget.

2. In order to ensure that a uniform state policy of privatisation is maintained, the State Committee of the Russian Federation for the Management of State Property shall:

- elaborate and submit to the Russian Federation Council of Ministers a draft State Programme for Privatisation, as well as changes and additions thereto on an annual basis, and also draft laws and other regulations on privatisation;

- organise and supervise carry out the Programme;

- annually report back to the Russian Federation Supreme Soviet on Programme fulfilment;

- summarise proposals for privatisation, coming from Local Councils of People's Deputies, worker collectives, social organisations (associations), ministries and agencies;

- establish arrangements for bonuses to be paid to staff members of agencies of state government and of local administrations, based on the results achieved in carry out the State Programme for Privatisation;

- exercise guidance in terms of counselling on methods, as well as control, over privatisation through its territorial agencies. In cases of violations of Russian Federation legislation on privatisation or of the State Programme for Privatisation, the State Committee of the Russian Federation for the Management of State Property shall lodge complaints with a court of justice or a court of arbitration in order to reverse the illegal decisions and bring the officials at fault to account;

- set up commissions for privatisation of enterprises in ownership of the Russian Federation;

- take decisions on privatisation of enterprises owned by the Russian Federation, carry out their requisite organisational and legal transformation, and convey the certificates of ownership of the same (equities, shares) for sale to the Russian Federal Property Fund pursuant to Article 15 below. By decision of the Russian Federation Council of Ministers, the State Committee of the Russian Federation for the Management of State Property may transfer such enterprises to the property funds of republics making part of the Russian Federation or those of regions, territories, autonomous regions, autonomous areas, districts (with the exception of boroughs in cities) or cities (excluding cities under district jurisdiction);

- assist with establishment of investment funds and holding companies; and

- issue norm-setting acts regulating the process of privatisation within its terms of reference and make changes and additions thereto, as well as provide explanations of such regulations and of the State Programme for Privatisation.

The State Committee of the Russian Federation for the Management of State Property may not delegate its powers to ministries, agencies and holding companies based on state concerns, on corporations or on associations or to other economic entities not deemed buyers pursuant to Para 1 of Article 9 below.

3. The State Committee of the Russian Federation for the Management of State Property shall prepare proposals for dividing state property into that in the ownership of the Russian Federation, that in the ownership of republics within the Russian Federation, that in the ownership of regions and so on down to territories, autonomous regions and autonomous areas, as well as into the municipal property of districts, cities and the administrative-territorial entities that are part thereof. Decisions on such delimiting of property shall be passed by the Russian Federation Supreme Soviet, the Supreme Soviets of republics making part of the Russian Federation, and by local Councils of People's Deputies in accordance with procedures established by legislation in effect in the Russian Federation and in republics within the same.

In the absence of a decision (certificate) confirming the property rights of a republic within the Russian Federation or of a region, territory, autonomous region, autonomous area, city, district or an administrative-territorial entity making part thereof, to any object of privatisation, the same shall be privatised by the State Committee of the Russian Federation for the Management of State Property as property of the Russian Federation.

4. Decisions taken by the State Committee of the Russian Federation for the Management of State Property within its terms of reference in execution of the State Programme for Privatisation shall be binding on all agencies of state government and of the local administration.

Disputes arising in connection with such decisions shall be considered by a court of justice or a court of arbitration in accordance with procedures established by applicable legislation.

ARTICLE 5. PROPERTY MANAGEMENT COMMITTEES OF REPUBLICS WITHIN THE RUSSIAN FEDERATION, OF REGIONS, TERRITORIES, AUTONOMOUS REGIONS, AUTONOMOUS AREAS, DISTRICTS (WITH THE EXCEPTION OF BOROUGHS IN CITIES) AND CITIES (WITH THE EXCEPTION OF CITIES UNDER DISTRICT JURISDICTION)

1. Privatisation of property in the ownership of republics within the Russian Federation, of regions, territories, autonomous regions, autonomous areas, districts (with the exception of boroughs in cities) and cities (with the exception of cities under district jurisdiction) shall be organised by the property management committees making part of the appropriate agencies of state government or of the local administrations (hereinafter the property management committees of ethnic-state and ethnic- or administrative-territorial entities).

Property management committees shall be established in all such ethnic-state and ethnic- or administrative-territorial entities and shall be agencies of state government (the local administration) with the right of a corporate body. The powers of property management committees may not be transferred to any other agencies of state government or of the local administration or to other corporate bodies. The committee chairman shall *ex officio* be a deputy head of government of the appropriate republic within the Russian Federation or a deputy head of the administration of the appropriate region, territory, autonomous region, autonomous area, city or district.

Regulations on a property management committee shall be approved by the appropriate Councils of People's Deputies. Such Regulations may not contradict the standard Regulations on a Property Management Committee to be endorsed by the Government of the Russian Federation. The activities of the said committees shall be financed at the expense of receipts from privatisation of state and municipal enterprises in the ownership of the appropriate ethnic-state or ethnic- or administrative-territorial entities.

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2. To carry out privatisation, the property management committees of ethnic-state and ethnic- or administrative-territorial entities shall:

- elaborate and submit to the appropriate Councils of People's Deputies draft republican or local privatisation programmes and annual changes and additions thereto, as well as draft regulations on privatisation, with due regard for the requirements set forth by the State Programme for Privatisation;

- organise and monitor carry out of the State Programme for Privatisation and of republican or local privatisation programmes and report annually on fulfilment thereof back to the appropriate Councils of People's Deputies;

- establish arrangements for bonuses to be paid to staff members of agencies of state government and of local administrations, enterprises and institutions, who are involved with privatisation programmes;

- set up commissions for privatisation of enterprises in state or municipal ownership of ethnic-state or ethnic or administrative-territorial entities;

- take decisions on privatisation of such enterprises, carrying out their organisational and legal transformation, and convey certificates of ownership thereof for sale to the appropriate property funds. By decision of the appropriate Councils of People's Deputies, such objects of privatisation may be transferred to the Russian Federal Property Fund;

- assist with establishment of investment funds and holding companies; and

- send their representatives to serve on commissions for privatisation of property of the Russian Federation to be established by the State Committee of the Russian Federation for the Management of State Property.

The committees may not delegate their powers to ministries, agencies and holding companies based on state concerns, on corporations or on associations or to other economic entities not deemed buyers pursuant to Para 1 of Article 9 below.

3. Decisions taken by such committees within their terms of reference in execution of the State Programme for Privatisation and of republican and local privatisation programmes shall be binding upon all agencies of state government and of the local administration.

Disputes arising from such decisions shall be considered by a court of justice or a court of arbitration in accordance with procedures established by applicable legislation.

4. On instructions from the State Committee of the Russian Federation for the Management of State Property, such committees may privatise owned by the Russian Federation.

ARTICLE 6. RUSSIAN FEDERAL PROPERTY FUND

1. The Russian Federal Property Fund and representatives appointed thereby shall be deemed the sole sellers of state enterprises in the ownership of the Russian Federation that are marked for privatisation, as well as of ownership interests (equities, shares) that are owned by the Russian Federation in the capital of enterprises.

The Fund shall be a corporate body, shall be set up by decision of the Russian Federation Supreme Soviet Presidium and shall be accountable to the same, as well as to the Russian Federation Supreme Soviet. Regulations on the Fund shall be approved by the Russian Federation Supreme Soviet. The activities of the Fund shall be financed at the expense of receipts from privatisation of state enterprises in the ownership of the Russian Federation. The Fund shall set up its local branches.

2. The Russian Federal Property Fund shall perform the following functions:

- temporarily hold certificates of ownership of enterprises and of ownership interests (equities, shares) in the capital of joint-stock companies (partnerships), which are owned by the Russian Federation and have been transferred to the Fund by the State Committee of the Russian Federation for the Management of State Property;

- exercise the proprietor rights of the Russian Federation at the general meetings of shareholders (stockholders) and bear a risk (responsibility) for the activities of enterprises to the extent of the ownership interests held by the Fund in the capital of such enterprises;

- sell such ownership interests (equities, shares) of enterprises;

- act as a founder of joint-stock companies (partnerships) and acquire shares and equities of joint-stock companies and partnerships, the development of which is determined by the tasks of accelerated structural reorganisation of the national economy, environmental protection and development of the socially and economically most backward regions, with the exception of those [joint-stock companies and partnerships that have been] established through transformation of state and municipal enterprises;

- draw and remit dividends and receipts from privatisation of enterprises in accordance with income taken into account in the republican budget of the Russian Federation and with norms established by the State Programme for Privatisation;

- exchange shares of joint-stock companies that belong to the Russian Federation for shares of investment funds and holding companies in establishment thereof;

- exercise control over granting of benefits envisaged by applicable legislation to the employees of enterprises marked for privatisation; and

- carry out state registration of privatisation deals.

The Russian Federal Property Fund may not delegate its powers to ministries, agencies and holding companies based on state concerns, on corporations or on associations or to other economic entities not deemed buyers pursuant to Para 1 of Article 9 below.

3. All shares of any joint-stock company owned by the Fund, the voting shares may not account for more than 20 per cent; the remaining shares owned by the Fund, regardless of their quantity and nominal status, shall be preference shares pursuant to this Law. On sale by the Fund of such shares, they shall be converted into common shares.

The Fund and its branches shall not have the right to interfere in the activities of enterprises, with the exception of cases envisaged by the fund documents of such enterprises and by legislation in effect in the Russian Federation and in republics making part of the same.

4. The Russian Federation Supreme Soviet shall annually consider and approve a report on the activities of the Russian Federal Property Fund for the past year.

ARTICLE 7. PROPERTY FUNDS OF REPUBLICS WITHIN THE RUSSIAN FEDERATION, OF REGIONS, TERRITORIES, AUTONOMOUS REGIONS, AUTONOMOUS AREAS, DISTRICTS (WITH THE EXCEPTION OF BOROUGHS IN CITIES) AND CITIES (WITH THE EXCEPTION OF CITIES UNDER DISTRICT JURISDICTION)

1. The sellers of state and municipal enterprises, as well as of ownership interests (equities, shares) in the capital of enterprises in the ownership of republics making part of the Russian Federation, of regions, territories, autonomous regions, autonomous areas, districts (with the exception of boroughs in cities) and of cities (with the exception of cities under district jurisdiction), shall be the property funds of the appropriate ethnic-state or ethnic- or administrative territorial entities or representatives duly appointed thereby.

Such funds shall be corporate bodies, shall be established by decision of the Presidiums of the Supreme Soviets of republics within the Russian Federation or the Presidiums of the appropriate local Councils of People's Deputies and shall be accountable to the same and to such Councils. Regulations on a fund shall be endorsed by the appropriate Council of People's Deputies.

The activities of property funds shall be financed out of funds received in the form of deductions from the amounts of transactions effected thereby in privatisation of state and municipal enterprises at rates to be established by the State Programme for Privatisation.

2. Property funds shall perform the following functions:

- temporarily hold certificates of ownership of state (municipal) enterprises and ownership interests (equities, shares) in the capital of joint-stock companies (partnerships), which are owned by republics within the Russian Federation, by regions, territories, autonomous regions, autonomous areas, districts or cities and have been transferred to such funds by the appropriate property management committees for sale;

- exercise appropriate proprietor rights at the meetings of shareholders (stockholders) and bear a risk (responsibility) for the activities of enterprises to the extent of the ownership interest held by such funds in the capital of such enterprises;

- sell such ownership interests (equities, shares) of enterprises;

- act as founders of joint-stock companies and partnerships and acquire equities and shares of joint-stock companies and partnerships, the development of which is dictated by the interests of the local population, with the exception of those [joint-stock companies and partnerships that have been] established by way of transformation of state and municipal enterprises;

- draw and remit dividends and receipts from privatisation of enterprises in accordance with income taken into account in the appropriate budgets and with norms established by the State Programme for Privatisation and by republican and local privatisation programmes;

- exchange shares of joint-stock companies that belong to the appropriate ethnic-state or ethnic- or administrative-territorial entities for shares of investment funds and holding companies in establishment thereof;

- exercise control over granting of benefits envisaged in the applicable legislation to the employees of enterprises marked for privatisation;

- may not delegate their powers to ministries, agencies and holding companies based carry out state registration of privatisation deals. Funds on state concerns, on corporations and on associations or to other economic entities not deemed buyers pursuant to Para 1 of Article 9 below.

3. Of the shares of any joint-stock company that are owned by a fund, the voting shares may not account for more than 20 per cent of the overall number of the shares of a company; the remaining shares owned by the Fund, regardless of their quantity and nominal status, shall be preference shares pursuant to this Law. In sale by the fund of such shares, they shall be converted into common shares.

The funds and their branches shall not have the right to interfere in the activities of enterprises, with the exception of cases envisaged by the fund documents of such enterprises and by legislation in effect in the Russian Federation and in republics making part of the same.

4. The Supreme Soviets of republics within the Russian Federation shall annually consider and approve a report on the activities of the appropriate property fund for the past year.

ARTICLE 8. INVESTMENT FUNDS AND HOLDING COMPANIES

1. Investment funds shall be established with the aim of setting up a primary securities market and lowering the risks of share purchasers. Regulations on investment funds shall be approved by the Russian Federation Council of Ministers.

2. An investment fund shall have the right to own not more than 10 per cent of the voting shares of a joint-stock company and to invest not more than 5 per cent of its assets in the securities of the same.

3. Investment funds shall publish their quarterly, semi-annual and annual reports according to the form established by the Russian Federation Ministry of Finance. The activities of such funds shall be subject to mandatory annual audits.

4. Holding companies may be set up on the basis of enterprises making part of amalgamations (associations, concerns) or enterprises under the control of agencies of state government or of the local administration by agreement with the Russian Federation State Authority on Anti-Monopoly Policies and Support for New Economic Entities with a view to arranging co-production schemes involving allied enterprises. Establishment of holding companies resulting in monopoly in the manufacture of specific products or performance of specific services (works) shall be prohibited.

Regulations on procedures for establishment of holding companies on the basis of amalgamations, associations, concerns, ministries and agencies shall be approved by the Russian Federation Supreme Soviet.

ARTICLE 9. BUYERS

1. Corporate bodies, the ownership interest of the state, of the local Councils of People's Deputies, social organisations (associations) and of charity and other public funds in the authorised capital of which exceeds 25 per cent, may not -- in privatisation of state and municipal enterprises -- be buyers or bidders in tender or at auctions or acquire shares of such enterprises marked for privatisation.

2. The obligation to prove their right to purchase enterprises slated to be privatised shall rest with the buyers. In order to participate in auctions or tender or to acquire shares of such enterprises, corporate bodies seeking to be buyers shall present to the appropriate property funds declarations detailing the make-up of partners in the respective joint-stock company (partnership) and the break-down of the authorised capital thereof. Should it come to light at a later date that at the time of sale of an enterprise marked for privatisation (equities, shares) a corporate body had no legal right to make the purchase, the transaction shall be deemed invalid pursuant to legislation in effect in the Russian Federation.

3. Staff members of state and municipal enterprises may act as buyers thereof and set up a partnership or joint-stock company for this purpose. Benefits established by this Law shall be enjoyed by them, as well as by former employees of enterprises marked for privatisation, who have retired on a pension or worked at such enterprises for at least 10 years in the case of men or 7.5 years in the case of women and left such enterprises on their own initiative or under a staff-reduction plan, as well as by persons entitled pursuant to legislation to return to their former jobs at such enterprises.

ARTICLE 10. REPRESENTATIVES AND INTERMEDIARIES

In privatisation, sellers and buyers may act through their representatives (authorised persons) and employ the assistance of intermediaries in accordance with legislation in force in the Russian Federation and in republics making part thereof.

ARTICLE 11. SOURCES OF FUNDS FOR ACQUISITION OF STATE AND MUNICIPAL ENTERPRISES

1. The personal savings of individuals, registered privatisation deposits, personal privatisation accounts and the own funds of corporate bodies listed in Para 1 of Article 9 above, as well as borrowed funds, shall be used to buy state and municipal enterprises.

Procedures for gratis transfer to individuals of state and municipal property by way of remittance by the state of privatisation deposits to registered privatisation accounts and for use of such accounts in privatisation shall be determined by the Law of the Russian Federation "On Registered Privatisation Accounts and Deposits".

Money from the incentive funds of enterprises slated for privatisation may be used by their staffs in accordance with procedures and in amounts to be established by the State Programme for Privatisation.

2. The legal tender of the USSR, including the registered privatisation deposits of individuals, shall be used to buy state and municipal enterprises in privatisation.

3. In acquisition of enterprises marked for privatisation or of ownership interests (equities, shares) in the capital of a joint-stock company (partnership), individuals shall be obliged to present a certificate from the tax inspection service if their contribution in roubles exceeds 500 statutory minimum monthly wages.

ARTICLE 12. USE OF RECEIPTS FROM PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES

1. Funds received from privatisation of state and municipal enterprises shall be distributed in accordance with rates to be established by the State Programme for Privatisation or by republican or local privatisation programmes. Such funds shall be exempt from all taxes.

2. Guidelines for spending receipts from privatisation of state and municipal enterprises within the frameworks set by Para 1 of this Article shall be established by the Russian Federation Supreme Soviet, by the Supreme Soviets of republics within the Russian Federation and by local Councils of People's Deputies.

CHAPTER II. PROCEDURES FOR, AND WAYS AND MEANS OF, PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES

ARTICLE 13. INITIATIVE IN PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES

1. Initiative in privatisation of state and municipal enterprises may ensue from the State Committee of the Russian Federation for the Management of State Property, territorial agencies thereof, the property management committees of ethnic state and ethnic- or administrative-territorial entities, the manager of an enterprise, or the staff of an enterprise, plant, production bay or other divisions of such enterprise, from buyers listed in Article 9 above, or again from other entities, including allied enterprises, banks, creditors, and agencies of power and administration.

Applications for privatisation of enterprises shall be submitted to the territorial agencies of the State Committee of the Russian Federation for the Management of State Property or to the property management committees of ethnic-state or ethnic or administrative-territorial entities. The form of such application and the amount of state duty payable upon submission thereof shall be determined by the Russian Federation Council of Ministers.

2. Applications from worker collectives shall be accepted for consideration if signed by at least half of all staff members of the given enterprise. Such applications shall be regarded as a statement of intent by the staff to found a partnership (joint-stock company) pursuant to Articles 15, 32 and 33 of the Law of the Russian Federation "On Enterprises and Entrepreneurial Activities" in privatisation of the enterprise.

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ARTICLE 14. PROCEDURES FOR CONSIDERATION OF APPLICATIONS FOR PRIVATISATION

1. Applications for privatisation of state and municipal enterprises shall be registered by the State Committee of the Russian Federation for the Management of State Property or a territorial agency thereof or by the property management committee of the appropriate ethnic-state or ethnic- or administrative-territorial entity on the day of filing of the same with such committee. Decisions on privatisation of an enterprise or on refusal to allow it to be privatised shall be passed by the appropriate committee within a month of registration of the application. The decision with respect to such application either on privatisation or on refusal to allow privatisation shall be brought in writing to the notice of the individuals, corporate bodies or worker collectives that have filed the registered application within three days of taking of such decision.

2. Refusals to allow privatisation of state or municipal enterprises may only take place in the following cases:

- if the applicant cannot be deemed a buyer pursuant to Article 9 above;

- if there are statutory restrictions on privatisation of the given enterprise;

- if the enterprise is on the list of facilities (groups of facilities) not subject to privatisation, which have been established by the State Programme for Privatisation or by republican or local privatisation programmes; and

- if the enterprise specified in the application has privatised before.

3. In the event that a decision on privatisation has been taken, a commission for privatisation of the enterprise shall be formed and a time-frame established for preparation of the appropriate privatisation plan. Such time-frame may not exceed three months after filing of the application.

The time-frame for elaboration of the privatisation plan may be extended by decision of the State Committee of the Russian Federation for the Management of State Property, but to no more than six months.

The commission for privatisation shall be obliged to consider draft privatisation plans submitted by the applicants.

4. The commission for privatisation of an enterprise shall include representatives of the State Committee of the Russian Federation for the Management of State Property, a territorial agency thereof or the property management committee of the appropriate ethnic-state or ethnic- or administrative-territorial entity, and officials of financial agencies. The Council of People's Deputies in the area where the enterprise is located, the management and staff of the enterprise, and the Russian Federation State Authority for Anti-Monopoly Policies and Support for New Economic Entities shall have the right to send their representatives to serve on the commission. The commission shall have the right to enlist experts, as well as specialised auditing, consulting and other organisations, in its work.

5. The commission shall examine the plan for privatisation of the enterprise and send it for endorsement by the local Councils of People's Deputies or a representative duly authorised thereby, as well as to the staff of the enterprise. Should the Council of People's Deputies and the staff of the enterprise fail to take an appropriate decision within a week of receipt of the privatisation plan, the same shall be deemed endorsed. The time-frame for endorsement of the privatisation plan by the Council of People's Deputies and the staff may be extended at their request, but to no more than two weeks. The privatisation plan shall be approved by the appropriate property management committee.

Facilities and enterprises included in the State Register of Monopolist Associations and Enterprises shall be privatised by agreement with the Russian Federation State Authority for Anti-Monopoly Policies and Support for New Economic Entities if their charter fund exceeds Rbs500,000.

6. The privatisation plan of an enterprise shall determine the form and time-frame of privatisation, the initial price of such enterprise, the amount of the authorised capital of the joint-stock company or partnership, and the recommended form of payments (settlements). It may also include a plan for reorganisation of such enterprise, which may envisage, in particular, divesting divisions of the same to act as independent enterprises (including determination of authorised capital thereof) or sale of the assets of the enterprise.

In privatisation, enterprises may not be merged with or attached to others or stripped of the status of a corporate body (with the exception of cases of their liquidation with subsequent sale of their assets).

7. Should the staff reject a privatisation plan, the commission shall be obliged to propose another version of such plan. In the event of repeat rejection of the privatisation plan by the staff, ultimate say on finalising of the plan, on the form of privatisation and on procedures for the same shall belong to the appropriate Council of People's Deputies or an agency duly authorised thereby.

8. If a local Council of People's Deputies rejects a plan for privatisation of an enterprise in the ownership of the Russian Federation, the commission shall be under an obligation to propose another version of such plan. In the event of repeat rejection of the privatisation plan, the final decision shall be taken by the State Committee of the Russian Federation for the Management of State Property.

9. Should a privatisation plan be approved, the enterprise shall be included by the appropriate committee in the plan/schedule for tender, auctions or for transformation of enterprises into joint-stock companies.

10. If requested by the Russian Federal Property Fund, branches thereof or by the property management committees of the appropriate ethnic-state or ethnic- or administrative-territorial entity, the commission shall be obliged to submit all available documents and reference material on an enterprise being privatised.

ARTICLE 15. FORMS OF PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES

1. State and municipal enterprises shall be privatised by way of their purchase through tender or at an auction, through sale of ownership interests (shares) in the capital of such enterprises or through redemption of the property of enterprises leased out fully or partially.

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Privatisation of enterprises through sale of ownership interests in their capital (shares) shall be carried out after transformation of state or municipal enterprises into joint-stock companies. Procedures for such conversion shall be laid down by regulations to be approved by the State Committee of the Russian Federation for the Management of State Property.

2. The property of a state or municipal enterprise leased out with the right of redemption thereof pursuant to a lease agreement concluded prior to entry into force of the Russian Federation Law "On Privatisation of State and municipal Enterprises in the Russian Federation" shall be privatised in the following ways:

- pursuant to the lease agreement if the amounts, time-frame, procedures and other terms and conditions of redemption have been established by the same with granting of all benefits envisaged for the staff of a state and municipal enterprise to the staff of the leasehold enterprise; and

- through transformation of the leasehold enterprise into an open-type joint-stock company with the leaseholders' right of first refusal to shares owned by the state or by the local Councils of People's Deputies if such decision has been taken by a general meeting (conference) of the leaseholders.

The leaseholders of trading, public-catering and consumer-service enterprises not enjoying the right to redeem leased property under the terms and conditions of the appropriate lease agreements concluded therewith prior to entry into force of the Russian Federation Law "On Privatisation of State and Municipal Enterprises in the Russian Federation" may be granted such right should members of the leaseholder collective agree to the spinning off of individual divisions of such enterprises in the process of privatisation.

Procedures for granting the right of redemption, for conclusion of a supplementary agreement and for conversion of a leasehold enterprise into a joint-stock company shall be laid down by Regulations on Procedures for Privatisation of Property of Leased-Out State and Municipal Enterprises to be endorsed by the State Committee of the Russian Federation for the Management of State Property.

In other cases, the lessor of the property of a state (municipal) enterprise deemed a buyer pursuant to Article 9 above may only win the right to redeem leased property in accordance with procedures established by Articles 20, 21 and 24 below.

3. The following shall be taken into account by the commission for privatisation when choosing the recommended form of privatisation:

- opinion of the staff of the enterprise;

- proposals from buyers, submitted to the appropriate property management committee along with the application for privatisation;

- sectoral characteristics of the facility slated for privatisation;

- evaluation of its authorised capital;

- socio-economic significance of the enterprise to the given territory; and

- opinion of the representative of the property fund.

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4. Decisions on the form of privatisation of an enterprise and on the form of payment shall be adopted by the State Committee of the Russian Federation for the Management of State Property, territorial agencies thereof or the property management committees of the appropriate ethnic-state or ethnic or administrative-territorial entity in accordance with Procedures established by Article 14 above.

5. After the commission for privatisation completes its work, the State Committee of the Russian Federation for the Management of State Property, a territorial agency thereof or the property management committee of the appropriate ethnic-state or ethnic- or administrative-territorial entity shall reorganise or liquidate the state (municipal) enterprise, found a joint-stock company and transfer its shares and founder rights or the enterprise marked for privatisation or again the assets of the liquidated enterprise for sale to the Russian Federal Property Fund or to the property fund of the appropriate republic within the Russian Federation or of the appropriate region, territory, autonomous region, autonomous district, district or city.

6. The Russian Federal Property Fund and the property funds of republics within the Russian Federation, of regions, territories, cities (except cities under district jurisdiction) and of districts (except boroughs in cities) shall annually conclude with the State Committee of the Russian Federation for the Management of State Property and the appropriate property management committees, within a month of endorsement of the State Programme for Privatisation, agreements regulating procedures for transfer of enterprises marked for privatisation, of ownership interests (equities, shares) in the capital thereof and of the assets of enterprises either in the process of being liquidated or already liquidated and for execution of documents required there for, procedures and standard time-frames for sale of property slated for privatisation (including on a category-by-category basis), and mutual payments procedures, and defining the mutual liability of the parties.

Such agreements may also determine the powers of the committees as representatives of the property funds.

7. Closed-type joint-stock companies (limited-liability partnerships), part of the authorised capital which is in state and/or municipal ownership, shall be subject to conversion into open-type joint-stock companies. Procedures and time-frames for such conversion shall be established by the Programme for Privatisation.

ARTICLE 16. PREPARATION OF ENTERPRISE FOR PRIVATISATION

1. Preparation of an enterprise for privatisation shall include stock-taking of its fixed assets and non-production assets marked for privatisation, as well as reorganisation of such enterprise, including detachment of divisions thereof to act as independent enterprises (including determination of the authorised capital thereof).

2. The make-up of social-infrastructure assets on the balance of an enterprise and guidelines for using such assets shall be determined in reorganisation of such enterprise.

Should such assets be included among property marked for privatisation, the buyer shall have the right to use them in any manner consistent with the requirements of legislation in effect in the Russian Federation, with the agreement between the buyer and the seller and with the collective-bargaining agreement.

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ARTICLE 17. DETERMINATION OF INITIAL PRICE OF ENTERPRISES SLATED FOR PRIVATISATION

The initial price of an enterprise for sale thereof in tender (at an auction) or the amount of the authorised capital of a joint-stock company may not be determined other than pursuant to Instructions on Methods of Evaluation of Property Slated for Privatisation to be endorsed by the State Committee of the Russian Federation for the Management of State Property.

ARTICLE 18. INFORMATION ON STATE AND MUNICIPAL ENTERPRISES MARKED FOR PRIVATISATION

1. Information on state and municipal enterprises offered for sale through tender or at an auction, on sale of shares of joint-stock companies, and on the results of privatisation deals shall be published in the special newsletters of property funds (in the case of enterprises, the authorised capital of which exceeds Rbs50 million -- in the newsletter of the Russian Federal Property Fund) at least a month before the date of such tender, auction or public offering of the shares. In privatisation of property in municipal ownership, the appropriate property management committee may establish a shorter notice period, but one of no less than two weeks.

2. The following information about enterprises marked for privatisation must be publicised:

- size of the site and the characteristics of the buildings located thereon, as well as the terms and conditions of their lease or sale;

- ownership interests (equities, shares) in the Capital of other enterprises, which are owned by the enterprise in question;

- intangible assets (patents, trademarks and others);

- obligations of the enterprise (including commercial, budget and credit obligations);

- balances of the enterprise for the previous year;

- detailed range of products manufactured; and

- average number of employees.

Upon presentation by the Russian Federation State Authority for Anti-Monopoly Policies and Support for New Economic Entities and territorial agencies thereof, data shall be published on the share of products (works, services) of the enterprise marked for privatisation on the appropriate commodity market.

The form, in which the data shall be submitted, and the list of additional data to be provided shall be decided by the State Committee of the Russian Federation for the Management of State Property.

3. Privatisation shall be carried out under the public supervision of employees of the enterprises being privatised, buyers, social organisations (associations) and people's deputies.

ARTICLE 19. FORMS OF PAYMENT

1. Payments for acquired enterprises or ownership interests (equities, shares) in the capital of joint-stock companies (partnerships) may be one-off or by instalments.

2. Redemption of the property of a state or municipal enterprise pursuant to a lease agreement shall be deemed payment by instalments.

Lease payments for use of the property of state or municipal enterprises may not be taken into account in payment for purchase of the property.

3. The form of payment shall be determined in an agreement between the seller and the buyer and may be among the terms and conditions of acquisition of an enterprise through tender.

ARTICLE 20. ACQUISITION OF STATE AND MUNICIPAL ENTERPRISES THROUGH TENDER

1. State and municipal enterprises, as well as the assets of liquidated enterprises (including those in the process of being liquidated), shall be sold through tender in cases where buyers are required to fulfil certain terms and conditions as established by the appropriate property management committee.

2. General procedures for arranging bids shall be governed by regulations to be endorsed by the Government of the Russian Federation. The regulations shall define the terms and conditions of buyer participation in bids procedures for examining bids, and procedures for endorsement of the decision taken and for formalisation of the title to the appropriate enterprise.

The terms and conditions of bids shall be published at least 30 days before the date of tender.

In privatisation of property in municipal ownership, the appropriate property management committee may establish a shorter notice period, but one of at least two weeks.

3. Sale of an enterprise through tender shall be carried out by a tender commission to be formed by the Russian Federal Property Fund, by local branches thereof or by the property fund of the appropriate ethnic-state or ethnic- or administrative-territorial entity with the involvement of the worker collective, the local Council of People's Deputies and the Russian Federation State Authority for Anti-Monopoly Policy and Support of New Economic Entities, as well as experts enlisted by them.

4. The tender commission shall determine the terms and conditions, procedures and time-frame of tender.

5. The purchase price of an enterprise shall be determined in the course of competitive bid examination. It may not be more than 25 per cent below the initial price. Should an enterprise fail to be sold in tender, it shall be withdrawn from the same.

6. The priority right to buy enterprises specialising in the traditional handicrafts and trades of the peoples of the north and small ethnic groups shall belong to members of the indigenous population. Privatisation of such enterprises shall be based on their residual value.

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ARTICLE 21. ACQUISITION OF STATE AND MUNICIPAL ENTERPRISES AT AUCTIONS

1. State and municipal enterprises, as well as the assets of liquidated enterprises, shall be sold through auctions in cases, where buyers are not required to meet any terms and conditions.

In such case, property rights shall go to the highest bidder.

2. Procedures for holding auctions, the terms and conditions of buyer participation therein, and procedures for payments and for registration of the right of ownership shall be determined by regulations to be approved by the Russian Federation Council of Ministers.

3. Auctions shall be held by the Russian Federal Property Fund, its local branches, the property funds of ethnic-state and ethnic- or administrative-territorial entities, or their duly appointed representatives.

4. The purchase price of an enterprise at an auction shall be determined in the course of the bidding. It may not be lowered by more than 30 per cent of the initial price. Should the enterprise fail to be sold at such price, it shall be withdrawn from the auction. In such case, the commission for privatisation shall review the plan for privatisation of the enterprise and (or) its initial price within a month.

ARTICLE 22. ACQUISITION BY BUYERS OF SHARES OF OPEN JOINT-STOCK COMPANIES

1. The founder of an open joint-stock company established on the basis of a state or municipal enterprise shall be the State Committee of the Russian Federation for the Management of State Property, a territorial agency thereof or the property management committee of the appropriate ethnic-state or ethnic or administrative-territorial entity. Pursuant to Article 34 of the Law of the Russian Federation "On Enterprises and Entrepreneurial Activities", the founder shall submit the decision to establish the joint-stock company, an application for registration, the company charter and the certificate of payment of state duty to the Council of People's Deputies in the area, where the enterprise is located, for registration.

2. After registration of a joint-stock company, the property management committee shall hand over the founder rights and the appropriate share holding to the appropriate property fund.

3. The fund shall sell the shares to the staff members of the enterprise marked for privatisation on preferential terms pursuant to Article 23 below within a month of fund of the company. Part of the shares may be transferred to the enterprise employee joint-stock company establishment fund established pursuant to Article 25 below, or may be exchanged for shares of investment funds. The shares shall be sold pursuant to regulations on sale of shares in privatisation to be endorsed by the State Committee of the Russian Federation for the Management of State Property.

4. The shares remaining unsold shall remain at the disposal of the Russian Federal Property Fund or the property funds of the appropriate ethnic-state or ethnic or administrative-territorial entities.

ARTICLE 23. BENEFITS TO EMPLOYEES OF ENTERPRISES BEING PRIVATISED WITH RESPECT TO ACQUISITION OF SHARES THEREOF

1. The employees of state and municipal enterprises transformed into joint-stock companies shall have the right to acquire shares of such enterprises on easy terms. The discount on the price of a share of stock in such case shall amount to 30 per cent of the face value thereof. The face value of a share holding offered per staff member on easy terms shall not exceed the amounts established by the State Programme for Privatisation. The shares in excess of such amounts shall be acquired by enterprise employees on the same terms as everyone else.

A grace period for payment for shares acquired on easy terms by enterprise employees shall be granted for three years as of the moment of joint-stock company registration. In such case, the size of the down payment may not be less than 15 per cent of the face value of the shares.

2. Benefits with respect to acquisition of shares of a joint-stock company shall apply to former employees of the enterprise marked for privatisation, who have retired on a pension or worked at such enterprise for at least 10 years in the case of men or 7.5 years in the case of women and left such enterprise on their own initiative or under a staff-reduction plan, as well as to persons entitled pursuant to legislation to return to their former jobs at such enterprise.

3. The State Programme for Privatisation may establish extra benefits to employees of individual enterprises or groups of enterprises (industries).

ARTICLE 24. ACQUISITION OF STATE AND MUNICIPAL ENTERPRISES BY EMPLOYEES THEREOF THROUGH TENDER (AUCTION)

1. In order to take part in tender (an auction) to acquire a state or municipal enterprise as a buyer, members of its staff may, pursuant to the Russian Federation Law "On Enterprises and Entrepreneurial Activities", found a partnership (joint-stock company) or sign a joint-activity agreement.

2. If a partnership (joint-stock company) taking part in tender (an auction) or in an appropriate joint-activity agreement includes at least a third of the scheduled workforce of the enterprise marked for privatisation or of a division thereof, it shall have the right in acquisition of the enterprise (division thereof) to pay by instalments, as well as to use the part of the balance of the incentive fund proportional to the number of the employees, who have joined the partnership (joint-stock company) or signed the agreement.

3. Such partnership (joint-stock company) shall have the right to a grace period for payment in acquisition of the respective state or municipal enterprise. The grace period may not exceed three years and the down payment shall not be smaller than 25 per cent of the purchasing price of the enterprise.

This provision shall apply to the contracts of sale and lease agreements concluded prior to enforcement of this Law.

4. Should such partnership (joint-stock company) and other buyers offer identical competitive bids, such partnership (joint-stock company) shall have the priority right to acquire the enterprise.

ARTICLE 25. ACQUISITION OF SHARES (EQUITIES) FROM ENTERPRISE EMPLOYEE JOINT-STOCK COMPANY ESTABLISHMENT FUNDS

1. The staff of joint-stock companies (partnerships) shall have the right to buy shares (equities) from enterprise employee joint-stock company establishment funds if the same have been formed as a share of the authorised capital of the enterprise pursuant to the privatisation plan.

2. Such funds shall be formed with contributions from the Russian Federal Property Fund or from the property funds of the appropriate ethnic-state or ethnic- or administrative-territorial entities.

The decision on establishment of such fund shall be taken on the basis of an agreement with the buyer.

The size of such fund may not exceed 10 per cent of the enterprise's authorised capital.

No such funds shall be formed in auctioning off of the property and non-tangible assets of liquidated enterprises.

3. The unredeemed shares of such fund and the receipts from sale of shares (equities) shall be owned by the appropriate property fund or its appointed representative. The available resources of such fund shall be spent exclusively on acquiring shares (equities) of the appropriate joint-stock company (partnership). The shares (equity) not bought out from such fund shall not carry voting rights.

ARTICLE 26. SOCIAL GUARANTEES TO EMPLOYEES OF STATE AND MUNICIPAL ENTERPRISES BEING PRIVATISED

1. Enterprises acquired through tender or at an auction, as well as joint-stock companies and partnerships, shall be liable for obligations arising from employment arrangements under the collective-bargaining agreement in effect prior to privatisation.

2. Not later than six months after the date of registration by the buyer of the property rights thereof to a privatised state or municipal enterprise or the date of transformation of the same into a joint-stock company (partnership), its manager shall be obliged to conclude a collective-bargaining agreement with its staff, should the same decide so.

3. Acquisition of assets of a liquidated enterprise shall not encumber the buyer with any obligations that would be connected with employment arrangements previously in effect at such enterprise.

4. Discharge of the employees of a privatised enterprise and their subsequent employment shall be regulated by legislation on labour and employment in effect in the Russian Federation and in republics within the same.

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CHAPTER III. FINAL PROVISIONS

ARTICLE 27. EXECUTION OF PRIVATISATION DEALS

1. Regardless of the form of privatisation, the buyers and sellers of state and municipal enterprises shall sign agreements by and between themselves pursuant to legislation in force in the Russian Federation and in republics making part thereof.

2. These agreements shall include the following data: information about the seller, buyer and intermediary, the name of the enterprise and location thereof, the make-up and value of the enterprise's assets, including the price of the site (in the event of sale of the same) or the terms and conditions of lease thereof, the number and price of the shares of the joint-stock company (size of the equity in the limited-liability company), procedures for transfer of the enterprise, the form and time-frame of payment, mutual commitments by the sides regarding further uses of the enterprise, the terms and conditions under which the enterprise has been sold through tender, and other terms and conditions established by agreement by and between the parties.

3. The right of ownership of an enterprise shall pass from seller to buyer as of the moment of registration of the contract of sale in accordance with procedures established by legislation in effect in the Russian Federation.

The registered contract of sale shall be the document certifying the buyer's right of ownership. Non-performance of statutory actions to register contracts of sale shall be appealed against in a court of justice or a court of arbitration.

No state duties shall be levied on any privatisation deals and certificates.

4. Alteration of the organisational or legal form of an enterprise shall be registered pursuant to the Russian Federation Law "On Enterprises and Entrepreneurial Activities".

ARTICLE 28. OBLIGATIONS OF SELLER AND BUYER

1. The seller of a state or municipal enterprise shall be required to publish an announcement about privatisation of the same, show the assets of the enterprise and documents concerning the financial and economic status thereof to a buyer at his request, execute the transaction, and transfer the enterprise (property, equity, shares) to the buyer, as well as perform other obligations specified by the agreement between the seller and the buyer.

2. The buyers of state and municipal enterprises shall become successors in rights to the property rights and obligations thereof pursuant to the appropriate agreements and legislation in effect in the Russian Federation.

3. The legal rights of the sellers and the buyers indicated in this Article shall respectively end and arise as of the moment of registration of the agreement by and between them.

4. Disputes over recognition of privatisation deals to be null and void shall be examined in accordance with the procedures and within the time-frames established by legislation in effect in the Russian Federation.

ARTICLE 29. STATE GUARANTEES OF RIGHTS OF PARTICIPANTS IN PRIVATISATION

The state shall guarantee respect for the rights of sellers, buyers, their representatives and intermediaries in privatisation. If privatisation has been in violation of legislation in force in the Russian Federation on privatisation of state and municipal enterprises, the State Committee of the Russian Federation for the Management of State Property, the property management committees of the appropriate ethnic-state or ethnic- or administrative-territorial entities, agencies of the Russian Public Prosecutor's Office, sellers, buyers, their representatives and intermediaries shall start legal proceedings for abrogation of the respective transaction, rectification of the violations, and bringing of those at fault to account.

The Council of People's Deputies shall exercise control over privatisation from the standpoint of correspondence thereof to applicable legislation.

ARTICLE 30. INVALIDITY OF PRIVATISATION DEALS

1. Transactions to purchase state or municipal enterprises shall be deemed invalid in the following cases:

- if privatisation of the enterprise has not been authorised by the State Committee of the Russian Federation for the Management of State Property, a territorial agency thereof or the property management committee of the appropriate ethnic-state or ethnic- or administrative-territorial entity;

- if the rules of the tender or of the auction have been grossly violated;

- if the buyer has refused to pay the purchase price or ownership interest (equity, shares) in the capital of the joint-stock company (partnership);

- if the enterprise or the ownership interest (equity shares) in the capital of the joint-stock company (partnership) has been acquired by an entity that does not have the right to do so;

- if illegal payment facilities have been used to make the purchase;

- if there has been collusion between the seller and the buyer on an illegitimate division of the property or on a reduction in the price of the enterprise (equity, shares);

- if the buyer has been granted illegal preference and benefits compared with other bidders;

- if the terms and conditions, under which the enterprise was acquired through tender, have been violated;

- if the requirements of the Russian Federation's anti-monopoly legislation have been violated; and

- for other reasons envisaged by the Russian Federation Civil Code.

2. Privatisation deals concluded in violation of this Law shall be deemed invalid in accordance with procedures established by legislation in force in the Russian Federation.

3. Disputes over recognition of privatisation deals to be invalid shall be examined in a court of justice or a court of arbitration on the basis of statements of claim to be lodged by the seller, buyer, intermediary, public prosecutor, a people's deputy of the Russian Federation, a member of the Council of People's Deputies, the State Committee of the Russian Federation for the Management of State Property, a territorial agency thereof, the property management committee of the appropriate ethnic-state or ethnic- or administrative-territorial entity, and other duly authorised state agencies in accordance with procedures and within time-frames established by legislation in force in the Russian Federation and in republics making part of the same.

ARTICLE 31. LIABILITY FOR VIOLATIONS OF THIS LAW

1. The following violations of this Law by officials of agencies of state government, of the local administration, property funds, enterprises, organisations and of institutions shall entail administrative liability:

- refusal to register an application for privatisation - punishable by a fine amounting to 5 to 10 guaranteed statutory minimum monthly wages;

- violation of time-frames for taking a decision on privatisation - punishable by a fine amounting to 5 to 10 guaranteed minimum monthly statutory wages;

- failure to publish an announcement about privatisation, concealment of information about an enterprise marked for privatisation from customers or intermediaries, misleading of a customer or intermediary about the make-up or price of the enterprise on sale, or concealment of information about the fact that the enterprise has been sold or about the results of tender or an auction -- punishable by a fine amounting to 10 to 30 guaranteed statutory minimal monthly wages. Data listed in this Paragraph shall be published at the expense of the official at fault;

- unjustified refusal to sell an enterprise (shares) -- punishable by a fine amounting to 2 to 10 per cent of the initial price of the enterprise marked for privatisation (shares);

- unjustified refusal to conclude a collective-bargaining agreement with the staff of a privatised enterprise or failure to fulfil demands for social guarantees to employees of enterprises marked for privatisation -- punishable by a fine amounting to 10 to 100 guaranteed statutory minimum monthly wages;

- disclosure of data about bidders before the start of tender or an auction -- punishable by a fine amounting to 2 to 20 guaranteed statutory minimum monthly wages; and

- refusal to pay for an enterprise (shares) required through tender or auction -- punishable by a fine amounting to 5 to 20 per cent of the selling price of the enterprise marked for privatisation (shares).

2. Procedures and time-frames for examining claims of offences listed in this Article and of other wrongdoing in privatisation shall be established by the Russian Federation Code on Administrative Offenses.

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3. Claims of offences listed in Para 1 of this Article shall be examined by judges on their own, either based on statements (complaints) filed by property management committees, sellers, buyers, intermediaries, Russian Federation people's deputies, Councils of People's Deputies, officials of agencies of state power and management, local administrations, social organisations (associations) or on the initiative of a public procurator.

4. Property management committees and property funds at every level shall have the right where it concerns issues falling under their terms of reference pursuant to legislation in effect in the Russian Federation and republics within the same and to decisions by Councils of People's Deputies:

- to appear in a court of justice or a court of arbitration on behalf of the Russian Federation, republics within the same or appropriate ethnic- or administrative-territorial entities; and

- to send material to public prosecutor offices for decision-making on opening of criminal cases.

Such agencies shall be exempt from state duties in recourse to judiciary authorities.

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STATE PROGRAMME OF PRIVATISATION OF STATE AND MUNICIPAL ENTERPRISES IN THE RUSSIAN FEDERATION FOR 1992 ADOPTED BY THE SUPREME SOVIET OF THE RUSSIAN FEDERATION ON 11TH JUNE 1992

1. INTRODUCTION

The State Programme of Privatisation of State/Municipally-Owned Enterprises of the Russian Federation for 1992 (hereinafter referred to as the Programme) has been developed in accordance with the terms of the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the RSFSR and shall establish the goals, targets, and the procedure of privatisation for 1992 and limitations in this area. The principal objectives of privatisation in 1992 shall be:

- to form a group of private owners contributing to the emergence of a socially oriented market economy;

- to raise the efficiency of enterprises through their privatisation;

- to ensure a safety net and to develop social infrastructure using the proceeds of privatisation;

- to contribute to the process of financial stabilisation in the Russian Federation;

- to provide a competitive environment and contribute to the demonopolisation of the national economy;

- to attract foreign investments; to provide the environment and institutional structures to expand the scale of privatisation in 1993-1994.

The requirements of the Programme shall be binding on all state bodies and authorities of republics within the Russian Federation, the autonomous region, autonomous districts, territories, regions, the cities of Moscow and St. Petersburg, as well as for local self governing bodies.

State/municipally-owned objects shall be divided, depending on the possibility of privatisation thereof in 1992, into following groups:

- objects and enterprises whose privatisation shall not be allowed;

- objects and enterprises that will only be privatised by a decision of the Government of the Russian Federation or the Governments of the republics within the Russian Federation (depending on the type of state property);

- objects and enterprises that will be privatised by a decision of the State Committee of the Russian Federation for the Management of State Property (hereinafter the GKI of Russia) taking into account the opinion of sectoral ministries;

- objects and enterprises that may be privatised only under local privatisation programmes;

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- objects, enterprises and structural units thereof privatised in the cases envisaged by the Law of the Russian Federation on the Privatisation of State/Municipally-Owned Enterprises of the Russian Federation, with the consent of their workers' collectives;

- objects and enterprises subject to mandatory privatisation.

Privatisation of property not included in binding targets and not subject to privatisation-related restrictions shall be conducted under local privatisation programmes or privatisation applications.

The Programme will not cover privatisation of State farms, land and housing.

2. CLASSIFICATION OF OBJECTS AND ENTERPRISES DEPENDING ON THE POSSIBILITY OF PRIVATISATION THEREOF IN 1992

2.1 OBJECTS AND ENTERPRISES WHOSE PRIVATISATION SHALL NOT BE ALLOWED IN 1992

2.1.1. Mineral, water and forest resources, airspace, continental shelf resources, territorial waters and sea economic zone of the Russian Federation, as well as the right to launch communications satellites into certain areas of the geostationary orbit and to operate them.

2.1.2. Natural territories that are protected or reserved for special use.

2.1.3. Historic and cultural heritage of the peoples of Russia (unique cultural and natural monuments as well as objects of historic, cultural, scientific and technological value including valuables stored in state museums, archives and libraries, including the premises in which they are located).

2.1.4. Funds of the federal budget of the Russian Federation, the Republican currency reserve of the Russian Federation, those of the Pension Fund of the Russian Federation and state extra-budgetary funds, the Central Bank of the Russian Federation as well as the gold reserve and the diamond reserve.

2.1.5. The Central Bank of the Russian Federation and enterprises, organisations and establishments ensuring the issue and storage of banknotes, Treasury notes, bonds and other state securities. Facilities and enterprises involved in the sorting of precious stones and affinage factories.

2.1.6. Organic and reserve equipment under the operational command of the Armed Forces of the Russian Federation, as well as that of the troops of the Security Ministry and the Ministry of the Interior of the Russian Federation.

2.1.7. Agencies financed out of budgets of all levels.

2.1.8. Enterprises and agencies of geological, mapping/geodetic and hydrometeorlogical services as well as those of services of environmental monitoring and of environmental protection.

2.1.9. Enterprises and agencies of the hygiene and epidemiologic, veterinary and forest and plant protection services.

2.1.10. Patent, standards and metrology agencies, and machine-testing facilities.

2.1.11. Pipeline facilities, enterprises, organisations and institutions.

2.1.12. Facilities of water-use and improvement systems and structures, as well as facilities and enterprises operating them.

2.1.13. TV and radio broadcasting centres.

2.1.14. Motor roads of general use and maintenance organisations.

2.1.15. Enterprises producing state awards and insignia.

2.1.16. Enterprises producing drugs and poisonous substances as well as those responsible for planting, cultivation and processes of narcotic and poisonous plants.

2.1.17. Port structures and facilities, nuclear-powered, training and hydrography ships, lighters, rescue ships and ships fighting oil spills at sea, the Atomflot repair and technology enterprise, the waterways and canals production associations, property owned by the detachment of Underwater River Construction Agency as well as shipping inspectorate.

2.1.18. Facilities, enterprises and equipment for the burial of solid industrial and household waste, solid and liquid radioactive waste as well as cattle burial grounds.

2.1.19. Facilities and enterprises of medical institutions and the prison system.

2.1.20. Civil engineering infrastructure facilities (including electricity, thermal energy and gas supply, water and sewerage pipelines, and street lighting) as well as city and district development facilities, and enterprises operating, maintaining,and servicing the above facilities.

2.1.21. Gas supply facilities of inter-regional and national importance.

2.1.22. Crematoria and cemeteries.

2.1.23. Enterprises producing fissionable and radioactive substances, nuclear weapons, and spacecraft; enterprises and facilities dealing with servicing, launches and tracking of spacecraft, as well as those engaged in research and development in the above fields.

2.1.24. Social security organisations and agencies, orphanages, old people's homes, boarding schools, hospitals and sanatoriums for disabled persons, children and senior citizens, as well as organisations and agencies involved in the prevention and treatment of mental, psycho-neurological, contagious, cancer, and skin and venereal patients, addicts as well as HIV-infected and AIDS-afflicted persons.

Note: Privatisation restrictions specified in 2.1.11, 2.1.12, 2.1.14, 2.1.21 shall be applied only to enterprises (divisions) dealing directly with the operation and maintenance of the facilities and systems referred to therein.

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2.2. OBJECTS AND ENTERPRISES TO BE PRIVATISED ONLY BY DECISION OF THE GOVERNMENT OF THE RUSSIAN FEDERATION OR THE GOVERNMENTS OF THE REPUBLICS WITHIN THE RUSSIAN FEDERATION (DEPENDING ON THE TYPE OF STATE OWNERSHIP)

2.2.1. Facilities and enterprises producing and repairing any weapons systems and components, producing ammunition, explosives and fireworks, as well as those engaged in research and development in the above fields.

2.2.2. Civil defence and mobilisation facilities and installations.

2.2.3. Facilities and enterprises producing nuclear-related equipment.

2.2.4. Specialised grain elevators, refrigerators, and storage facilities designed for permanent storage of state and mobilisation reserves and stocks.

2.2.5. Extracting enterprises (excluding those producing raw materials under local authorities).

2.2.6. Enterprises processing precious metal ores, precious and semi-precious gems, radioactive and rare earth products.

2.2.7. Fuel and energy complex enterprises and associations (except for construction and construction-related enterprises) including electric power, coal, oil and gas producing and processing enterprises, export trans-shipment oil installations as well as oil installations of national and inter-regional importance.

2.2.8. Commercial banks (to be privatised in accordance with a special procedure).

2.2.9. Communications enterprises (except those within the "Rospechat" retail network).

2.2.10. Information and wireless agencies subordinate to the Press and Information Ministry of the Russian Federation.

2.2.11. Social, cultural and entertainment facilities (health, education, culture and sports) facilities and agencies in federal ownership or in the state ownership of republics within the Russian Federation, irrespective of their departmental affiliation (excluding facilities owned by enterprises and organisations).

2.2.12. Wholesale facilities servicing the Far North or equal regions including rotation settlements.

2.2.13. Foreign trade associations of the Foreign Economic Relations Ministry of the Russian Federation and other ministries and departments of the Russian Federation.

2.2.14. Printing enterprises and printing houses.

2.2.15. State-owned sanatoriums and resorts.

Applications to privatise facilities and enterprises specified in Section 2.2 of this Programme shall be submitted to the territorial agencies of GKI of Russia to be forwarded to the State Committee of the Russian Federation for the Management of State Property of which the applicant must be notified. Decisions on applications shall be made by the Deputy Chairman of the Government of the Russian Federation at the submission of GKI of Russia and the relevant ministry. Decisions on such applications shall be made within one month of their being filed with the territorial agencies of GKI of Russia.

This procedure shall be followed in relation to those facilities and enterprises referred to in Section 2.2. that cannot be regarded as those within the scope of Section 2.1. of this Programme.

2.3. OBJECTS AND ENTERPRISES TO BE PRIVATISED EXCLUSIVELY BY A DECISION OF GKI OF RUSSIA TAKING INTO ACCOUNT THE OPINION OF SECTORAL MINISTRIES

2.3.1. Enterprises in all sectors of national economy dominating at the federal or local level markets of products, works and services but not covered by Sections 2.1. and 2.2 of this Programme.

2.3.2. Large enterprises (with more than 10,000 employees or a book value of fixed assets over 150 million roubles as of January 1, 1992), not covered in Sections 2.1. and 2.2.

2.3.3. Real estate and property being released as a result of reductions in the Armed Forces of the Russian Federation except weapons to be eliminated in accordance with the international obligations of the Russian Federation as well as the released property of the Security Ministry of the Russian Federation and the Ministry of the Interior of the Russian Federation.

2.3.4. Railroad, air, maritime and river transport enterprises.

2.3.5. Construction enterprises and enterprises of national importance producing construction materials and structures.

2.3.6. State-owned cattle-breeding and horse-breeding plants, selection and hybridisation facilities, state seed inspectorates and laboratories testing the brands of agricultural crops, brand testing farms and grounds, farms breeding valuable and anadromous species of fish, State farms and animal farms.

2.3.7. Higher and specialised secondary establishments. Research and design centres as well as enterprises and establishments affiliated to the Russian Academy of Sciences, sectoral Academies, the Ministry of Health, and the Ministry of Sciences, Higher Education and Technological Policy of the Russian Federation, the Ministry of Education of the Russian Federation, Ministry of Environment and Natural Resources of the Russian Federation, and facilities of state research centres.

2.3.8. Medical equipment facilities and enterprises (including pharmacology and production of biomedical medications) except those specified in Section 2.1.16 of this Programme.

2.3.9. Enterprises producing alcohol, liquor, wine and tobacco products.

2.3.10. Enterprises and agencies producing infant food.

2.3.11. Mobilisation stocks (to be excluded from property of privatised enterprises).

2.3.12. Petrochemical supply facilities.

2.3.13. Enterprises of folk crafts and art.

Decisions on privatising facilities and enterprises covered in Section 2.3. of this Programme shall be made by GKI of Russia. Ministries and departments of the Russian Federation shall provide their opinion on draft decisions upon its request.

This procedure shall be followed in relation to those facilities and enterprises referred to in Section 2.3. that cannot be regarded as those within the scope of Sections 2.1 and 2.2. of this Programme.

When enterprises and facilities specified in Sections 2.2. and 2.3. above are privatised, GKI of Russia shall be entitled to keep controlling blocks of shares in federal ownership for a period of up to three years.

2.4. OBJECTS AND ENTERPRISES TO BE PRIVATISED EXCLUSIVELY UNDER LOCAL PRIVATISATION PROGRAMMES

2.4.1. Mass transit facilities (except taxis) and their maintenance and repair facilities.

2.4.2. Bath houses and laundries.

2.4.3. Funeral parlours except those referred to in 2.1.22 of this Programme.

2.4.4. Refuse processing plants.

2.4.5. Drugstores and pharmacies (subject to mandatory state licensing).

2.4.6. Social, cultural and entertainment facilities (health, education, culture and sports) facilities and agencies regardless of their departmental affiliation (except those covered by 2.2.11 and facilities owned by enterprises and organisations).

Decisions on privatising facilities and enterprises covered in Section 2.4 of this Programme shall be made by the relevant property management committees taking into account requirements of local privatisation programmes.

Restrictions on privatisation established by this Programme shall be binding on all state authorities, government agencies and local self-government bodies. No additional restrictions of privatisation may be imposed by these said bodies.

Privatisation of objects covered by the restrictions established by this Programme shall not be allowed without proper authorisation of appropriate bodies.

Privatisation restrictions under Sections 2.2. and 2.3. and 2.4. shall not imply any prohibition to transform state/municipally-owned enterprises into state/municipally-owned open-ended joint-stock companies.

Sale and purchase, transfer, exchange of shares or parts thereof between legal entities with a 25 per cent or greater share of state or municipal capital in their charter capital shall not be allowed unless otherwise provided by the laws of the Russian Federation.

2.5. OBJECTS AND ENTERPRISES SUBJECT TO MANDATORY PRIVATISATION

Objects and enterprises most influencing the emergence and operation of a market infrastructure in the economy of the Russian Federation, as well as objects and enterprises whose inefficient operation impedes the economic development of Russia and the emergence of a market shall be subject to mandatory privatisation.

Such objects and enterprises are:

2.5.1. Wholesale and retail objects and enterprises including those involved in the marketing of industrial goods, catering facilities and consumer services (including open departmental retail outlets, catering facilities and consumer services);

2.5.2. Construction and construction materials producing facilities and enterprises (organisations);

2.5.3. State agricultural objects and enterprises including poultry farms (except State farms);

2.5.4. Enterprises processing agricultural produce, servicing agriculture and producing industrial goods for this sector;

2.5.5. Food processing and light industrial enterprises;

2.5.6. Enterprises in all sectors of economy that operate at a loss except those specified in Section 2.1 of this Programme;

2.5.7. Halted projects and unfinished construction whose planned construction time has expired;

2.5.8. Assets of enterprises liquidated with no succession rights;

2.5.9. Road transport enterprises except those specified in 2.4.1.

3. PRIVATISATION TARGETS SET BEFORE STATE AUTHORITIES

3.1. Privatisation targets for 1992 set before republics within the Russian Federation are set forth in Table 1, those set before Territories, Regions, and the Cities of Moscow and St.Petersburg are set forth in Table 2, those set before the Autonomous Region, Autonomous Districts are set forth in Table 3.

3.2. The targets are expressed as relative values (the share of privatised objects as percentage of the total number of objects in an industry that are subject to privatisation) and shall be the necessary minimum to be incorporated in local privatisation programmes.

Targets for privatisation of enterprises specified in 2.5.6 and 2.5.7 shall not be established.

3.3. Committees for the Management of State Property of the republics within the Russian Federation, the Autonomous Region, Autonomous Districts Territories, Regions, the Cities of Moscow and St. Petersburg shall draft local programmes based on the targets of this Programme and shall make projections for expected proceeds of privatisation.

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Privatisation programmes approved by appropriate Councils of People's Deputies shall be submitted to GKI of Russia.

The Chairmen of Councils of People's Deputies, Heads of Administrations, Chairmen of GKIs and Chairmen of Property Funds at all levels shall be held personally responsible for ensuring that the targets set in this Programme are met.

4. RULES OF ALLOCATION OF PRIVATISATION PROCEEDS IN 1992 AND PROJECTIONS FOR SUCH PROCEEDS - 1992-1994

4.1 State/municipally-owned enterprises shall be privatised in 1992-1994 both on a remunerative and non-remunerative basis.

The projections of privatisation proceeds for enterprises to be privatised on a remunerative basis in 1992 presented as desegregated by industries in Table 4, have been calculated on the basis of effective demand for objects of privatisation in various industries and regions of the Russian Federation and will amount to 72 billion roubles, including:

- 15 billion roubles from personal savings of the population;

- 32 billion roubles from enterprises' economic incentives funds;

- 15 billion roubles from the funds of enterprises recognised as buyers under the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the RSFSR.

- 10 billion roubles from foreign investors.

Additional effective demand of the population will be provided in the fourth quarter of 1992 through the introduction of personal privatisation accounts (privatisation vouchers).

4.2. The projection of proceeds from privatisation in 1993 - 1994 is based on the effective demand for privatisation objects in various sectors and regions. Proceeds will amount to 350 billion roubles in 1993; 470 billion roubles in 1994.

Individual privatisation accounts and privatisation funds of enterprises shall be the major source for the purchase of privatised objects.

4.3. Proceeds of privatisation shall be allocated to appropriate budgets and management bodies in accordance with the rates shown in Table.

The allocation shall be valid after payments to the employees of privatised enterprises in accordance with the procedure established by the Programme.

4.4. The Government of the Russian Federation shall have the right to adjust the privatisation targets (upon consent of the republics within the Russian Federation) and rates of allocation of privatisation proceeds taking into account the state of the financial system of the Russian Federation and the situation on the property market.

4.5. No proceeds of privatisation shall be subject to taxation.

4.6. The property management committees and property funds at all levels shall be exempt from all taxes.

4.7. State duties shall not be levied on any privatisation transactions.

5. METHODS OF PRIVATISATION AND PRIVATISATION BENEFITS TO BE GRANTED IN 1992

5.1. A specific method for the privatisation of enterprises shall be selected by an appropriate committee for the management of state property guided by the results of work performed by a privatisation commission in accordance with the requirements of the Law of the Russian Federation on Privatisation of State/Municipally-Owned Enterprises in the Russian Federation, the State and local privatisation programmes, regulations issued by GKI of Russia and taking into account the opinion of the workers' collective of the enterprise subject to privatisation.

Formation of closed joint-stock companies as a result of transformation of state/municipally-owned enterprises shall not be allowed.

Formation of joint-stock companies (including holding companies) on the basis of concerns, leagues, agglomerations or other associations of enterprises comprising state/municipally-owned enterprises shall not be allowed except for the cases when their organisational and legal form made to conform with the laws of the Russian Federation

Property contributions made by state/municipally-owned enterprises to the charter capital of enterprises in any organisational or legal forms including associations of enterprises shall be deemed state/municipally-owned. Such contributions by enterprises shall be allowed only when duly authorised by the appropriate property management committees while their sale or other alienation shall be allowed only in accordance with the privatisation laws of the Russian Federation.

Formation of enterprises in any organisational and legal forms by associations of state/municipally-owned enterprises as well as by state authorities and local self government bodies shall not be allowed with the exception being committees for management of property and property funds acting within their competence as defined by the laws of the Russian Federation.

The successors of the above legal entities as founders and partners (shareholders) of previously formed enterprises shall be solely the appropriate property funds.

Decisions on separating structural units from enterprises in the course of their privatisation shall be made by appropriate committees for the management of property taking into account requirements of the Anti-Trust Law of the Russian Federation, in which case no consent of the workers' collective of the enterprise concerned shall be required. If the units are transformed into open joint-stock companies when they are separated, the managers of these units shall be fully entitled to benefits and advantages envisaged by 5.4 of the Programme.

5.2. All state/municipally-owned enterprises shall be divided into three categories depending on the method of privatisation used:

- Small-scale enterprises (with an average work force of up to 200 employees and book value of fixed capital less than 1 million roubles as of January 1, 1992) shall be sold at auction/tenders in accordance with the requirements hereof;

- Enterprises with an average work force of more than 1,000 employees or a book value of fixed capital of more than 50 million roubles as of January 1, 1992 shall be privatised by being transformed into open joint-stock companies;

- The remaining enterprises may be privatised by any of the methods established hereby.

5.3. The following privatisation methods under this Programme shall be used in 1992:

- sale of shares of open-end joint-stock companies; sale of enterprises at auctions;

- sale of enterprises through commercial tenders (including those with a limited number of bidders); sale of enterprises through non-commercial investment tenders (investment bidding); sale of property (assets) of enterprises being liquidated and already liquidated; buy-out of rented assets.

5.4. If shares of open joint-stock companies formed by transforming state/municipally-owned enterprises (including those transformed previously into closed joint-stock companies) are sold, one of the following options for the granting of benefits to members of the worker's collective of the enterprise subject to privatisation shall be used at the suggestion of the workers' collective with the benefits covering:

- employees whose principal job is at the enterprise;

- people who are entitled to be re-employed by the enterprise under the law of the Russian Federation; and

- pensioners who retired from the enterprise or former workers of enterprise who have worked at the privatised enterprise not less than for 10 years in the case of men and 7 years and 6 months in the case of women and were discharged voluntarily or as a result of staff cuts;

- persons discharged from this enterprise as a result of staff cuts after January 1, 1992 and registered as unemployed.

Option 1:

All employees of the enterprise subject to privatisation shall be given free of charge as a one-off benefit inscribed preferred (non-voting) shares representing 25% of the charter capital but not more than 20 minimum monthly wages established by law for one employee;

common shares representing up to 10% of the charter capital but not more than 6 monthly wages established by law for one employee shall be sold by subscription to employees at a 30% discount of their face value and with deferred payment for a period of 3 years, with the down payment not less than 15% of the face value of the shares;

administrative officers of the privatised enterprise (director, deputy directors, chief engineer, chief accountant) shall be granted an option to buy common shares at their face value, but the total amount received by all the above mentioned administrative officers shall not exceed 5 % of the charter capital or 2000 minimum monthly wages established by law for one employee.

Option 2:

All employees of the privatised enterprise shall be granted the right to buy common (voting) shares representing 51 % of the charter capital. In this event:

- neither a free-of-charge transfer of shares nor a concessionary sale of shares shall be allowed;

- the purchase price of the shares shall be determined according to the regulations issued by GKI of Russia;

- when transforming state/municipally-owned enterprises into joint-stock companies, property management committees may, at the request of the management of the enterprise subject to privatisation and upon agreement of the work collective, grant personally to employees of enterprises making part of a single technological complex with the enterprise subject to privatisation, the right to participate in a closed subscription for shares to be held among employees of the enterprise subject to privatisation;

- the total number of shares subject to the sale to employees of the transformed enterprise and to employees of enterprises making part of a single technological complex therewith may not exceed 51 per cent of the charter capital of the joint-stock company.

Option 3:

If a group of employees of an enterprise makes a commitment to carry out the privatisation plan of the enterprise and to avoid its bankruptcy, obtaining the agreement of the general meeting of the workers' collective to sign the appropriate agreement for a period of no more than one year (with no right of renewal), the members of such group shall be granted an option to buy, after the said agreement expires and its terms are carried out, 20 per cent of the charter capital in common shares of the enterprise at their face value. If the group fails to comply with the terms of the agreement, the right (option) shall be lost and the shares shall be sold under the established procedure.

The group shall be entitled to a vote equal to the 20 per cent voting power of the shares held by the appropriate property fund for the duration of the agreement.

The privatisation plan shall include the terms of the agreement that must be signed between the said group and the appropriate property fund. The agreement shall specify the obligations of the group members and the limits of their liability by the property they privately own (contributed as collateral) to the value of no less than 200 minimum monthly wages established by law of the Russian Federation for each member of the group.

When this option is used, common shares making up 20 per cent of the charter capital but not to excess of 20 minimum monthly wages established by law of the Russian Federation for one employee shall be sold to all employees of the enterprise (including the members of the group) at a discount of 30 per cent of their face value and under a 3-year deferred payment schedule.

In this case the down payment shall be of no less than 15 per cent of the face value of the shares.

Option 3 may be used only at enterprises with a work force of up to 200 employees and a book value of fixed assets from 1 million to 50 million roubles.

The decision to choose Option 2 or 3 shall be made by a general meeting of the workers' collective or certified by the signatures of the members of such collective. The decision shall be valid if voted for (signed) by at least 2/3 of the employees of the enterprise. In the absence of such a decision, benefits shall be granted under Option 1.

Under either option 10 per cent of proceeds from the sale of shares (except for shares sold to the members of the workers' collective of the privatised enterprise) shall be remitted to personal privatisation accounts of the enterprise's employees.

The procedure of free distribution of shares (under Option 1) as well as of distribution and transfer of proceeds to the employees' personal privatisation accounts shall be defined by the general meeting of the workers' collective.

Shares shall be sold to the employees of the enterprise within the benefits granted hereby through closed subscription in accordance with the Regulation to be approved by GKI of Russia. If the amount of the subscription exceeds the level envisaged in the option used, the privatisation commission of the enterprise shall decrease the shares of all employees in an equal proportion in order to comply with this restriction.

Shares bought or obtained free of charge under procedures mentioned above or acquired on other terms under the Regulation on the sale of stock to be approved by GKI of Russia may be sold by shareholders without any restrictions.

5.5. The sale at an auction shall mean the purchase of privatisation objects by legal entities and individuals for private ownership in open bidding when the buyers are not obliged to meet any requirements with respect to the object of privatisation.

The property right in this case shall be transferred to the buyer who offered the maximum price in the bidding.

In this event employees of the enterprise subject to privatisation as well as persons discharged from that enterprise as a result of staff cuts after January 1, 1992 and registered as unemployed, who have not obtained the ownership rights as a result of the auction, shall receive up to 30 per cent of the purchase price of the enterprise but not more than 20 minimum monthly salaries established by law of the Russian Federation for one employee.

5.6. The sale at a tender (commercial or non-commercial investment tender) shall mean the purchase of privatisation objects by legal entities and individuals for private ownership in the cases when buyers are obliged to meet certain of the following requirements with respect to the privatisation object (such as continuing sale of certain products or purpose of the object, preserving a certain number of jobs, financing of the social sector, preserving certain investment levels, etc.).

In this event employees of the enterprise subject to privatisation as well as persons discharged from that enterprise as a result of staff cuts after January 1, 1992 and registered as unemployed, shall receive up to 20 per cent of the purchase price of the object but not more than 15 minimum monthly salaries established by law for one employee.

The commercial tender may be held as open bidding or closed tender.

The right to purchase the object of privatisation shall be granted to the buyer who offered the maximum price at the commercial tender.

The sale through commercial tender with a restricted number of bidders shall be allowed (in accordance with the local privatisation programmes) to privatise trade, catering and customer service facilities, upstream agro-processing enterprises, as well as production and maintenance enterprises servicing agriculture located in rural areas and townships; in the Extreme North or equivalent areas. Only employees of such privatised enterprises, local residents and persons expelled from the area (including those outside of the Russian Federation) during mass repressions may bid at such tenders.

Non-commercial investment tenders shall be held to sell state/municipally-owned enterprises when the buyer is required to carry out an investment programme. In this case the right of ownership shall be granted to the buyer whose proposal best meets the criteria established by the privatisation plan.

A regulation on investment tenders shall be approved by GKI of Russia.

When state/municipally-owned enterprises (as well as assets of liquidated enterprises) are sold at a tender or auction to a partnership (joint-stock company) comprising at least 1/3 of the employees of the privatised enterprise (unit), or purchased (except for buy out situations), such partnership or joint-stock company shall be entitled to a discount of 30 per cent of the purchase price and a deferred payment plan for a term of 3 years. The size of the down payment must be at least 25% of the purchase price.

5.7. Individuals and legal entities winning the ownership of privatised state/municipally-owned enterprises at an auction/tender shall have the right to sign long term (at least 15 years) lease contracts for the state/municipal non-residential premises, buildings and structures occupied by those enterprises but not making part of the acquired assets, as well as the right to acquire for ownership the said premises, buildings and structures (not earlier than one year after the contract of purchase and sale of the enterprise enters into force) as well as land occupied by those enterprises under the procedure established by the Government of the Russian Federation. Any changes in the terms as compared to the lease contracts previously signed by those enterprises shall be allowed only by agreement of the parties, unless otherwise provided by the contract.

5.8. Should an individual or a legal entity recognised as buyer under Article 9 of the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the RSFSR be the only bidder at an auction or tender, the enterprise shall be sold to the said individual or entity at a price determined under the procedure established by GKI of Russia. The enterprise shall be sold within two weeks of the auction/tender by the relevant property fund. Employees of the enterprise who have become the buyer shall not be granted benefits in case of such a sale.

5.9. The property (assets) of enterprises liquidated or subject to liquidation shall be sold exclusively at auctions.

In this event employees of the enterprise as well as persons discharged from that enterprise as a result of staff cuts after January 1, 1992 and registered as unemployed, shall be paid up to 30 per cent of the purchase price of the property (assets) but not more than 20 minimum monthly wages established by law of the Russian Federation per one employee.

5.10. Rented state/municipally-owned property may be privatised by various methods depending on whether the right to a buy-out is envisaged in the relevant contract on the consent of the workers' collective of the rented enterprise approved by at least one half of members of that collective.

Leaseholders who have the right to a buy-out under their lease contracts shall exercise this right as follows:

- in accordance with the lease contract entered into before the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the RSFSR came into force if the amount, terms, procedure and other conditions of a buy-out were established by the lease contract;

- through the transformation of the enterprise operating on the basis of lease of state/municipal property into an open joint-stock company with the right of priority buy-out of shares by the leaseholders, by the local Soviet of People's Deputies.

The collective of a structural division within wholesale and retail enterprise, catering facilities and consumer services operating under a lease contract envisaging a right to buy-out shall have the right, if it decides to transform into an independent enterprise, to buy out a share of state/municipal property proportionate to its share in the total production marketing of products, works and services, at a 30 per cent discount to the value stipulated in the lease contract.

Provisions of this paragraph shall cover leased enterprises and co-operatives only provided they are transformed into an appropriate organisational and legal form required by the law of the Russian Federation.

5.11. The right of buy-out of leased property shall be granted to partnerships formed by the workers' collectives of divisions separated from enterprises formed by workers' collectives of state/municipal enterprises before the entry into force of the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the RSFSR on the basis of lease of assets of those enterprises, that do not have such a right under the lease contract.

In these cases the said partnership shall also be granted the priority right of long term lease (for a term of at least 15 years) of state/municipally-owned non-residential premises, buildings and structures occupied by them as well as the right to buy them for ownership but not earlier than after one year since the rented property was bought out under the procedure to be established by GKI of Russia.

5.12. In 1992 state/municipally-owned enterprises (regardless of restrictions imposed on their privatisation) may set up, at the expense of remaining economic incentive and profit funds, a privatisation fund with personal privatisation accounts to be opened for employees. Funds remitted to the personal privatisation accounts shall not be subject to taxation.

In 1992 all remaining economic incentive funds as of January 1, 1992, and up to 50 per cent of actual profits retained by the enterprise after taxes and other mandatory payments may be remitted to the privatisation fund. The following assets may not be transferred to the privatisation fund:
- profits made by selling fixed capital of the enterprises and depreciation allowances.

Once state/municipally-owned enterprises are privatised, funds transferred to personal privatisation accounts shall be left at the disposal of employees. Should an employee be dismissed, those funds may be transferred at his or her request to privatisation account.

The right to ownership of the funds transferred to a personal privatisation account of the employee may be transferred to other persons by way of inheritance or gift. Funds from personal privatisation accounts may only be used by employees to buy any state/municipally-owned assets in the course of privatisation.

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5.13. For the purposes of protecting the interests of employees of enterprises subject to privatisation, from the decision of the workers' collective to file an application for privatisation of the state/municipally-owned enterprise or a division thereof or from the filing of application by another individual or legal entity and until the date when the property right of the buyer is created (the first meeting of shareholders is held) it shall not be permissible to:

- reorganise, liquidate or restructure the enterprise;

- alter or terminate previously signed contracts for the lease of premises, buildings, and structures occupied by the enterprise;

- without permission from an appropriate property management committee.

Any changes in the staff schedule or staff cuts shall not be permitted during this period without the agreement of the workers' collective of the enterprise or a division thereof.

5.14. In 1992 the following additional benefits shall be granted in the course of privatisation of state/municipally-owned enterprises:

- A partnership set up by employees of the enterprise where the number of disabled persons exceeds 50 per cent of the total number of employees shall have the priority right to buy their enterprise at the residual value thereof; if the ratio of disabled persons employed is less than 50 per cent but more than 10 per cent of the total number of employees, the terms of sale of the enterprise must include the commitment by the buyer to preserve the number of jobs reserved for disabled persons by the privatisation plan and to provide special working conditions for them;

- A partnership set up by at least 2/3 of the employees of state/municipally-owned enterprises engaged in traditional crafts and trades of peoples of the Extreme North (provided that at least 50 per cent of the members of the partnership are members of small ethnic groups indigenous to the area concerned) and engaged in traditional arts shall have the priority right to purchase the enterprise at the residual value;

- When privatising mining enterprises located in the Extreme North or equivalent, the benefits and advantages envisaged hereby for the members of their workers' collectives shall also cover former employees of those enterprises who have worked there for at least five years and the members of gold-mining teams leasing property of those enterprises who have worked there for at least five seasons;

- When privatising enterprises involved in the upstream agro-processing in the logistical support of agricultural production, shares may be sold through a closed subscription to agricultural producers in the territory of the relevant republic within the Russian Federation (autonomous region, autonomous district, territory, region) recognised as buyers under the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the Russian Federation.

6. TERMS OF LENDING FOR PRIVATISATION PURPOSES IN 1992

Commercial banks of the Russian Federation and foreign banks may finance privatisation transactions on commercial terms without restrictions.

The Central Bank of the Russian Federation shall not provide credits for these purposes.

Local privatisation programmes may envisage allocation of credits for these purposes out of the funds at the disposal of the Soviets of People's Deputies concerned.

7. USE OF INDIVIDUAL PRIVATISATION ACCOUNTS IN 1992

7.1. A system of individual privatisation accounts/vouchers shall be introduced no later than November 1, 1992. The Government of the Russian Federation shall submit the total amount to be transferred to individual privatisation accounts (allocated by vouchers) as well as the payment to each citizen for the approval of the Supreme Soviet of the Russian Federation no later than one month before the start of payments under the individual privatisation account/vouchers scheme.

7.2. For the purposes of servicing the circulation and distribution of funds on individual privatisation account/vouchers, the committees for the management of state property at all levels shall set up and promote the setting up of financial institutions (investment companies, funds, etc.) to ensure that the business community is broadly involved in these financial institutions.

7.3. GKI of Russia and local committees for the management of state property shall complete before September 1, 1992, the transformation of enterprises the book value of whose fixed capital exceeded 50 million roubles as of January 1, 1992, except those whose privatisation is not allowed under Section 2.1 hereof, into open joint-stock companies for the purposes of providing to citizens the opportunity of buying assets to be privatised using their individual privatisation account/vouchers. For these purposes, the managers of such enterprises shall be responsible for drafting constituent documents of open joint-stock companies and their privatisation plans based on requirements of the Law of the Russian Federation On Privatisation of State/Municipally-Owned Enterprises in the Russian Federation, this Programme and the standard documents approved by the Government of the Russian Federation. The draft plans shall be submitted by enterprise managers, upon agreement of the working collective, to appropriate property management committees before September 1, 1992.

8. USE OF FOREIGN INVESTMENTS

8.1. Foreign investments may be used for privatisation of state/municipally-owned enterprises on the following terms:

- Foreign investors may participate in auction, tender or investment bidding. In transactions with foreign investors, only appropriate committees for the management of state property may act as sellers of property subject to privatisation;

- If the foreign investor is the sole participant in the auction or commercial or investment tender, the enterprise concerned may be sold to such investor. In this event special valuation of the assets of the enterprise shall be conducted according to the methods approved by GKI of Russia;

- Foreign investors shall be allowed to take part in the privatisation of enterprises and facilities of, public catering and consumer services, as well as small-scale (with the average work force of no more than 200 employees or the book value of up to 1 million roubles as of January 1, 1992) of industry, construction and road transport only at the decision of local authorities or bodies duly authorised by them;

- Decisions to allow foreign investors to participate in the privatisation of enterprises and facilities of the fuel and energy complex, enterprises producing and processing precious metal ores, precious and semi-precious stones, precious metals, radioactive and rare-earth products, shall be made by the Government of the Russian Federation or the Governments of republics within the Russian Federation (depending on the type of state property) at the time when a decision is made to allow privatisation of such facilities and enterprises.

No other restrictions on foreign participation in privatisation shall be imposed.

8.2. Mutual payments under transactions with foreign investors shall be made in the currency of the Russian Federation taken from special bank accounts to be opened in accordance with the laws of the Russian Federation.

8.3. Foreign individuals not registered as entrepreneurs in their respective countries of origin shall be recognised as foreign investors with respect to their participation in privatisation.

9. MUTUAL RELATIONS BETWEEN STATE PRIVATISATION BODIES, AND THEIR RELATIONS WITH OTHER STATE AUTHORITIES AND BUDGETS OF ALL LEVELS

9.1. Appropriate property funds shall be the sellers of state/municipally-owned enterprises and other state/municipally-owned assets.

When the Government of the Russian Federation and GKI of Russia make a privatisation decision delegated to their competence by this Programme, they shall represent the interest of the autonomous region, autonomous districts, the territories, regions, the Cities of Moscow and St.Petersburg and ensure their protection.

Standing commissions of the Soviets of People's Deputies concerned shall supervise the fulfilment and validity of privatisation transactions.

In regions where property funds (offices of the Russian Federal Property Fund) have not been set up, all their functions shall be performed, at the request of the Soviets of People's Deputies concerned Russian Federal Property Fund, by appropriate property management committees.

9.2. Powers delegated by the appropriate property management committee to a ministry, department, or a local administration body shall expire when the decision is taken to privatise the enterprise concerned.

9.3. The ministries and departments of the Russian Federation shall develop their recommendations regarding the specific situation in their sector to be taken into consideration in the course of privatisation and exercising proprietary powers and submit such recommendations to GKI of Russia, upon obtaining the consent of the State Committee of the Russian Federation on Anti-Trust Policies and the Support of New Economic Ventures.

9.4. In order for the property funds at different levels to exercise their proprietary powers at shareholder meetings of joint-stock companies where controlling blocks of shares were reserved for the state, they may use as proxies representatives of appropriate ministries and departments of the Russian Federation and managers of enterprises.

10. THE SETTING UP OF AD HOC FINANCIAL FUNDS USING PRIVATISATION PROCEEDS

10.1. Privatisation proceeds shall be understood to include all cash revenues from the sale of objects of privatisation as well as other revenues obtained in the course of privatisation (including registration fees, deposits, etc.).

Dividends and lease payments obtained by property funds and property management committees shall not be considered proceeds of privatisation and shall be transferred to special accounts minus bank transaction fees.

10.2. Privatisation proceeds, except for funds on individual privatisation accounts/vouchers, received by appropriate Soviets of People's Deputies in accordance with the rates established hereby, shall be set aside to establish the following ad hoc funds:

- social safety nets for the population;

- implementation of environmental projects;

- demonopolisation and restructuring;

- development of social and civil engineering infrastructures of cities and regions as well as covering budget deficits.

Proceeds from privatisation of federal property under the operational command of the Armed Forces of the Russian Federation, the Security Ministry of the Russian Federation and the Ministry of the Interior of the Russian Federation shall be used to set up a fund for the social protection of servicemen.

10.3. The procedure for the setting up of such funds, amounts of money to be remitted for such purposes and the manner of expenditure shall be determined by the appropriate Soviets of People's Deputies.

11. REQUIREMENTS FOR LOCAL PRIVATISATION PROGRAMMES

11.1. Local privatisation programmes shall be developed by committees for the management of property of the constituent republics of the Russian Federation, autonomous region and autonomous districts, territories, regions, cities (except for towns below district-level centres), districts (except for city districts) and shall be approved by appropriate Soviets of People's Deputies which shall be entitled to assign privatisation-related tasks to government authorities and management bodies (local self-governing bodies) subordinate to them in accordance with this Programme.

11.2. Local privatisation programmes shall be developed amended in compliance with the requirement hereof and approved not later than one month after the publication of this Programme. Then the local programmes shall be published in the press of appropriate Soviets of People's Deputies and submitted to GKI of Russia.

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11.3. Local privatisation programmes shall be approved for a period of one year and shall meet the following binding requirements:

- not to be inconsistent with this, not to contain proposals on the privatisation of objects not subject to privatisation or subject to restrictions (except for Section 2.4) in accordance with this Programme, not to impose additional restrictions on privatisation of facilities and enterprises;

- to meet fully the binding requirements and objectives set by this Programme;

- to contain lists of specific objects groups of objects subject to mandatory privatisation for the purposes of achieving targets and meeting mandatory objectives under this Programme;

- to contain projections for expected proceeds from privatisation, the procedure and options for their use;

- to contain a list of privatisation-related restrictions to be imposed under paragraph 2.4. of this Programme;

- to envisage specific measures aimed at countering monopolies and providing a competitive environment, at using these ad hoc funds and foreign investments for these purposes.

11.4. Committees for the management of property of republics within the Russian Federation, of the autonomous region, autonomous districts, territories, regions, cities and districts may make amendments to local privatisation programmes with the consent of the appropriate Supreme Soviets and the Soviets of People's Deputies.

11.5. Forms and terms of submitting reports on the achievement of targets set by this Programme shall be established jointly by GKI of Russia and the Russian Federal Property Fund upon agreement with the State Statistics Committee of the Russian Federation.

11.6. Chairmen of the local Soviets of People's Deputies and property funds, heads of administrations and chairmen of local committees for the management of property shall be responsible for the implementation of local privatisation programmes.

11.7. GKI of Russia shall supervise the implementation of local privatisation programmes.

LAW OF THE RSFSR ON 'FOREIGN INVESTMENTS IN THE RSFSR' NO.1534, DATED APRIL 7, 1991

This Law defines the legal and economic funds for the investment of foreign capital on the territory of the RSFSR, and is aimed at attracting and efficiently using in the Russian Federation's economy, material and financial resources, advanced machinery and equipment and technologies, and managerial know-how from foreign countries.

The provisions of this Law are in force on the territory of the RSFSR and apply to all foreign investors and enterprises with foreign investments.

CHAPTER I. GENERAL PROVISIONS

ARTICLE 1. FOREIGN INVESTORS

Foreign investors in the RSFSR may be:

- foreign legal entities, including, in particular, any companies, firms, enterprises, organisations or associations set up and legally empowered to make investments in accordance with the legislation of the country where they are located;

- aliens, stateless persons and Soviet citizens domiciled abroad, provided they have been registered for the purpose of conducting economic activity in the country of their citizenship of permanent residence;

- foreign states;

- international organisations.

ARTICLE 2. FOREIGN INVESTMENTS

Foreign investments shall be all types of material and intellectual values placed by foreign investors in objects of entrepreneurial and other types of activity with the aim of deriving a profit (or an income).

ARTICLE 3. INVESTMENT OF FOREIGN CAPITAL

Foreign investors shall have the right to make investments on RSFSR territory by:

- holding shares in enterprises set up jointly with legal entities and citizens of the RSFSR and other Union republics;

- setting up enterprises that will wholly belong to foreign investors, and also subsidiaries of foreign legal entities;

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- acquiring enterprises, property complexes, buildings and other structures; participating and holding shares in enterprises, owning bonds and other securities; and also other property which, under the legislation in force on RSFSR territory, may belong to foreign investors;

- acquiring rights to use land and other natural resources;

- acquiring other property rights;

- engaging in other investment-related activities that are not prohibited by the legislation in force on RSFSR territory, including the granting of loans, credits, property and property rights.

USSR currency shall be used by foreign investors to make investments according to the procedure and under the terms prescribed by the legislation in force on RSFSR territory.

ARTICLE 4. OBJECTS OF FOREIGN INVESTMENT

The objects of foreign investment of RSFSR territory may be any objects that are not legislatively prohibited with respect to making such investments. They may include:

- newly formed and modernised fixed and current assets in all sectors and spheres of the national economy;

- securities;

- money deposits for specific purposes;

- scientific and technical products;

- rights to intellectual values;

- property rights.

ARTICLE 5. LEGAL REGULATION OF FOREIGN INVESTMENTS IN THE RSFSR

Relationships connected with foreign investments in the RSFSR shall be regulated by the present Law, and also by other legislative acts and international treaties effective on RSFSR territory. Where the rules laid down by an international treaty effective on RSFSR territory differ from those prescribed by legislative acts of the RSFSR, the rules of the international treaty shall be applied.

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CHAPTER II. STATE GUARANTEES OF THE PROTECTION OF FOREIGN INVESTMENTS

ARTICLE 6. THE LEGAL REGIME GOVERNING FOREIGN INVESTMENTS

Foreign investments made on RSFSR territory shall enjoy full and unconditional legal protection, which shall be guaranteed by the present Law, and by other legislative acts and international treaties in force on RSFSR territory. The legal regime governing foreign investments and the investment activity of foreign businessmen shall not be less favourable than the regime established for the property, property rights and investment activity of legal entities and citizens of the RSFSR, except for the cases envisaged by the present Law.

ARTICLE 7. GUARANTEES AGAINST CONFISCATION, AND ALSO AGAINST ILLEGAL ACTIONS ON THE PART OF STATE BODIES AND THEIR OFFICIALS

1. Foreign investments in the RSFSR shall not be subject to nationalisation, requisition or confiscation, except for the emergency cases envisaged by legislative acts, when such measures shall be taken in the public interests. In cases of nationalisation or requisition, the foreign investor shall be paid prompt, adequate and effective compensation.

Decisions on nationalisation shall be adopted by the Supreme Soviet of the RSFSR. Decisions on requisition and confiscation shall be passed according to the procedure stipulated by the legislation in force on RSFSR territory.

Decisions by bodies of state administration on the confiscation of foreign investments may be appealed against in RSFSR courts.

2. Foreign investors shall be entitled to compensation for damage, including missed gain, caused to them as a result of execution of instructions from RSFSR state bodies or their officials which contradict the legislation in force on RSFSR territory, and also as a consequence of these bodies or their officials improperly discharging their legislation stipulated duties towards the foreign investor concerned or towards an enterprise with foreign investments.

ARTICLE 8. COMPENSATION AND INDEMNIFICATION OF FOREIGN INVESTORS FOR LOSSES

1. The compensation payable to a foreign investor must correspond to the real value of his investments being nationalised or requisition i.e. to its value before the time when the actual or the forthcoming nationalisation or requisition became officially known.

The compensation must be paid without unjustified delay in the currency in which the investments were initially made, or in any other foreign currency acceptable to the foreign investor. Before payment, interest shall be added to the compensation sum in accordance with the interest rate effective on RSFSR territory.

2. Compensation for losses, including missed gain, caused to a foreign investor as a result of the actions indicated in Clause 2 of Article 7 shall be paid by the body which permitted the said actions to occur.

ARTICLE 9. THE PROCEDURE FOR RESOLVING DISPUTES

1. Investment-related disputes over the amount and terms or procedure for the payment of compensation shall be resolved in the Supreme Court of the RSFSR, unless a different procedure is laid down by the relevant international treaty effective on RSFSR territory.

2. The relevant international treaty effective on RSFSR territory may provide for recourse to international means of settling disputes arising in connection with foreign investments made on RSFSR territory.

ARTICLE 10. GUARANTEES OF TRANSFER OF PAYMENTS IN CONNECTION WITH FOREIGN INVESTMENTS

Foreign investors who have paid the appropriate taxes and fees shall be guaranteed unhindered transfer of payments abroad in connection with the investments made by them, provided these payments have been made in foreign currency, and in particular:

- income on investment derived, among other things, as profit, a share of profit, dividends, interest, licence fees and commissions, payments for technical aid and maintenance service, and other remunerations;

- sums payable on grounds of rights to money claims, and of demands to fulfil contractual obligations of economic value;

- sums received by investors in connection with partial or total liquidation, or the sale of their shares;

- compensations provided for in Article 8 of the present Law.

ARTICLE 11. GUARANTEES OF THE USE OF PAYMENTS IN USSR CURRENCY ON RSFSR TERRITORY

1. The payments indicated in Article 10 of the present Law and received by foreign investors in USSR currency from sources in the RSFSR and other Union republics may be re-invested on RSFSR territory and used in accordance with the legislation in force in the RSFSR.

Foreign investors may keep their rouble funds in current and settlement accounts with banks situated on RSFSR territory which have the appropriate licence of the Central Bank of the RSFSR, without the right to transfer abroad money from the said accounts.

Foreign investors may use their rouble funds in these accounts to purchase foreign currency on the domestic currency market according to the procedure prescribed by the legislation in force on RSFSR territory.

2. Enterprises with foreign investments that produce goods of key national-economic importance that replace imports which shall be confirmed by the findings of the RSFSR Ministry of Foreign Economic Relations, the RSFSR Council of Ministers, and the Councils of Ministers of the republics within the RSFSR) may, using the hard-currency fund of the RSFSR and those of the republics within the RSFSR respectively, and by agreement with the foreign investor concerned, convert his rouble profit into foreign currency at an agreed-upon rate, but not lower than the rate used by the State Bank of the USSR in its foreign-economic transactions.

CHAPTER III. THE ESTABLISHMENT AND LIQUIDATION OF ENTERPRISES WITH FOREIGN INVESTMENTS

ARTICLE 12. ORGANISATIONAL-LEGAL FORMS AND TYPES OF ENTERPRISES WITH FOREIGN INVESTMENTS

1. On the territory of the RSFSR enterprises with foreign investments shall be set up and operate as joint-stock companies and other economic societies and partnerships, as envisaged by RSFSR legislation.

2. On the territory of the RSFSR the following enterprises may be set up and operate:

- enterprises with foreign equity (joint ventures), and also their daughter enterprises and subsidiaries;

- enterprises wholly owned by foreign investors, and also their daughter enterprises and subsidiaries;

- subsidiaries of foreign legal entities.

ARTICLE 13. THE PROCEDURE FOR SETTING UP ENTERPRISES WITH FOREIGN INVESTMENTS

1. An enterprise with foreign investments may be set up either by founding one or as a result of a foreign investor acquiring shares in an enterprise founded earlier without foreign investments, or by his acquiring the entire enterprise.

2. Enterprises with foreign investments shall be founded according to the procedure stipulated by the legislation, effective on RSFSR territory, on enterprises and entrepreneurial activity, economic societies and partnerships, with due account taken of the addenda attached to the present Law.

3. Where a foreign investor acquires shares in an enterprise founded earlier without foreign investments, and also where he acquires such an enterprise, he shall do so in accordance with the procedure stipulated by the legislation in force on RSFSR territory, taking into account the addenda attached to the present Law.

ARTICLE 14. SUBSTANTIATION STUDY FOR ENTERPRISES WITH FOREIGN INVESTMENTS

1. When setting up an enterprise with foreign investments which involves large-scale construction or reconstruction, the appropriate preliminary substantiation study shall be carried out. In certain cases the establishment of enterprises with foreign investments shall necessarily require the relevant expertise of the sanitary-epidemiological services and an ecological inspection. All types of substantiation studies shall be conducted and the relevant permits issued according to the general procedure prescribed by the legislation in force on RSFSR territory.

2. With regard to enterprises with foreign investments whose ecological impact may affect the territory of more than one republic within the RSFSR, the ecological study shall be conducted by a joint commission set up on a parity basis by the relevant bodies of the republics concerned within the RSFSR. The required permits shall be issued by the RSFSR State Committee for Ecology and Use of Natural Resources on the strength of the report of a joint commission of experts.

ARTICLE 15. FOUNDING DOCUMENTS OF ENTERPRISES WITH FOREIGN INVESTMENTS

1. The founding documents of an enterprise with foreign investments must specify the object and purposes of its activity, the composition of the partners, the amount and procedure for forming its statutory capital, the value of the share of each of the partners, the structure, composition and competence of its management bodies, the decision-making procedure, the questions requiring unanimous decision, and the procedure for liquidating the enterprise. In addition to this, the founding documents may include other provisions that do not contradict the legislation in force of RSFSR territory and reflect the specific features of the enterprise's activity.

2. Contributions to the statutory capital of an enterprise with foreign investments shall be valued by agreement between its partners on the basis of world-market prices. Where such prices are lacking, the value of the contributions shall be determined by agreement among the partners. The valuation may be made either in USSR currency or in a foreign currency with the value of the contributions converted into roubles according to the exchange rate that the USSR State Bank applies in its foreign-economic operations.

ARTICLE 16. STATE REGISTRATION OF ENTERPRISES WITH FOREIGN INVESTMENTS

1. The state registration of enterprises with foreign investments shall be effected by the RSFSR Ministry of Finance or by another authorised state body.

Enterprises whose foreign investments exceed 100 million roubles shall be registered by the RSFSR Ministry of Finance with the permission of the RSFSR Council of Ministers. The RSFSR Council of Ministers must, within two months from the date the application is submitted to the RSFSR Ministry of Finance, issue a permit or provide the applicant with a well-founded reason for refusing.

2. The state registration of enterprises with foreign investments shall be effected where the following documents are available:

1) for joint ventures:

(a) the founders' written application requesting the registration of the enterprise being set up;

(b) two sets of notarised copies of the founding documents;

(c) the expertise required as provided for by the law;

(d) for Soviet legal entities, notarised copies of the decision of the owner of the assets to set up the enterprise concerned, or copies of the decision of a body authorised by him, and also notarised copies of the founding documents for each Soviet legal entity participating in the establishment of the joint venture concerned;

(e) a document attesting to the foreign investor's solvency issued by the bank or other credit-financial institution servicing him (with a certified translation into Russian);

(f) a statement from the commercial register of the foreign investor's country of origin, or an equivalent document testifying to his legal status in conformity with the legislation of the country where he resides, to his citizenship or domicile (with a certified translation into Russian);

2) for enterprises wholly belonging to foreign investors:

(a) the foreign investor's written application for registration;

(b) two sets of notarised copies of the founding documents;

(c) a document attesting to the foreign investor's solvency issued by the bank or other credit-financial institution serving him (with a certified translation into Russian);

(d) a statement from the commercial register of the foreign investor's country of origin (with a certified translation into Russian);

(e) in the cases provided for by the law, the relevant expertise;

3) for subsidiaries of enterprises with foreign investments and subsidiaries of foreign legal entities:

(a) an application for registration signed by the head of the enterprise setting up the subsidiary;

(b) a notarised copy of a statement from the decision of the enterprise's management body authorised to set up a subsidiary;

(c) two notarised copies of the subsidiary's statute;

(d) notarised copies of the founding documents of the enterprise setting up the subsidiary;

(e) as regards the foreign legal entity, a statement from the commercial register of his country of origin or an equivalent document testifying to his legal status in accordance with the legislation of the country where he resides (with a certified translation into Russian);

(f) in the cases provided for by the law, the relevant expertise.

3. Also subject to state registration shall be all addenda and amendments made in the founding documents of already registered enterprises with foreign investments, and in those of their subsidiaries, and also data on their liquidation.

A notarised copy of the decision of the competent body of the enterprise with foreign investments about the amendments or addenda made in its founding documents shall be presented by this enterprise to the registering body not later than 30 days after their adoption. The said amendments and addenda made in the founding documents shall take effect only upon their registration.

ARTICLE 17. TIME-LIMITS FOR THE REGISTRATION OF ENTERPRISES WITH FOREIGN INVESTMENTS

The Ministry of Finance of the RSFSR or another authorised state body must, within 21 days of the date of submission of an application, register the enterprise with foreign investments or communicate to the applicant the reasons for refusal.

A registered enterprise with foreign investments shall be issued a standard certificate of registration. An enterprise with foreign investments shall acquire the right of a legal entity from the moment of its registration. The local authorities in the area where the enterprise is situated shall be notified of the registration and announcement on registration shall be published in the press.

ARTICLE 18. REFUSAL TO REGISTER ENTERPRISES WITH FOREIGN INVESTMENTS

Denial of state registration to an enterprise with foreign investments shall be possible only where the procedure for forming such an enterprise, established by the legislation in force on RSFSR territory, has been violated, or where the documents necessary for registration are incompatible with it. Denial of registration may be appealed against in accordance with legal procedure.

ARTICLE 19. LIQUIDATION OF ENTERPRISES WITH FOREIGN INVESTMENTS

1. The liquidation of an enterprise with foreign investments shall be effected in the cases and in accordance with the procedure provided for by the legislation in force on RSFSR territory which applies to the respective organisational-legal forms of enterprises.

2. Should after a year following the registration of an enterprise with foreign investments there is no documentary confirmation that each of the partners has paid not less than 50 per cent of his contributions to the statutory capital as indicated in the founding documents, then the body that had registered the given enterprise shall declare the enterprise non-existent and pass a decision on its liquidation. Information about this shall be published in the press.

3. The registration of the liquidation of an enterprise with foreign investments shall be effected by the body that registered it on the strength of the report of the liquidation commission and of the liquidation balance sheet confirmed by an auditing organisation. Information of the liquidation shall be published in the press.

CHAPTER IV. CONDITIONS FOR THE FUNCTIONING OF ENTERPRISES WITH FOREIGN INVESTMENTS

ARTICLE 20. TYPES OF ACTIVITY

An enterprise with foreign investments may engage in any types of activity that meets the purposes provided for in the enterprise's Statute, with the exception of those prohibited by the legislation in force on RSFSR territory.

To conduct insurance and intermediary activities connected with the movement of securities, an enterprise with foreign investments must obtain a licence from the RSFSR Ministry of Finance. Banking requires a licence from the Central Bank of the RSFSR. The RSFSR Council of Ministers may specify other types of activity which shall be conducted by enterprises with foreign investments only on the basis of a special permit (or licence).

ARTICLE 21. DAUGHTER ENTERPRISES, SUBSIDIARIES AND REPRESENTATIVE OFFICES OF ENTERPRISES WITH FOREIGN INVESTMENTS

1. An enterprise with foreign investments may set up daughter enterprises having the rights of a legal entity, and also subsidiaries and representative offices on RSFSR territory and beyond its borders, including in foreign states, in compliance with the regulations established by the legislation in force on RSFSR territory, by the legislation of the Union republics, and/or by the relevant legislation of the foreign states concerned.

2. The subsidiaries and representative offices of enterprises with foreign investments shall operate on the basis of their statutes approved by these enterprises. They shall have the right to open accounts in banking institutions in the RSFSR.

ARTICLE 22. TERMS FOR THE REALISATION OF GOODS, OPERATIONS AND SERVICES ON THE MARKET OF THE RSFSR

An enterprise with foreign investments may, on a contractual basis, specify the terms for realising its products/operations/services on the market of the RSFSR including the prices for them, and also the terms for delivering goods and rendering services obtained on this market. The enterprise with foreign investments shall pay for the delivery of goods and the rendering of services obtained from the RSFSR market, and shall also pay rent for housing and non-dwelling premises on RSFSR territory, in USSR currency.

ARTICLE 23. ASSOCIATIONS AND UNIONS OF ENTERPRISES WITH FOREIGN INVESTMENTS

Enterprises with foreign investments may, on a voluntary basis, unite into unions, associations, concerns, and inter-sectoral, regional and other amalgamations on terms that do not contradict the anti-monopoly legislation in force on RSFSR territory and in accordance with the procedure prescribed by the legislative acts of the RSFSR.

Within the framework of such amalgamations the payments in hard currency by enterprises with foreign investments may be regulated.

ARTICLE 24. CUSTOMS DUTIES

1. Assets brought into the RSFSR as contributions of foreign investors to the statutory fund of enterprises with foreign investments within the time-limits established by their founding documents for its formation, and also assets intended for their own material production, shall be exempt from customs duties and import taxes.

2. Assets brought into the RSFSR by foreign employees of enterprises with foreign investments for their own needs shall be exempt from customs duties.

ARTICLE 25. EXPORT AND IMPORT OF GOODS AND SERVICES

1. Enterprises wholly owned by foreign investors and joint ventures with foreign investments amounting to more than 30 per cent in their statutory capital, shall be entitled without a licence to export their products and import goods for their own needs, except for the cases provided for by international agreements effective on RSFSR territory. The procedure for identifying goods of their own manufacture intended for export, and goods imported by the enterprises for their own needs, shall be established by the RSFSR Council of Ministers on the basis of the rules concerning the origin of goods that are accepted in to world practice.

2. The hard currency proceeds of the said enterprises from the export of their own products shall remain entirely at their disposal. The export and import of other goods/services shall be carried out by all enterprises with foreign investments on general terms.

ARTICLE 26. SELF-REPAYMENT IN HARD CURRENCY

All hard currency expenditures connected with the conduct by enterprises with foreign investments of various types of economic activity on RSFSR territory, including transfers abroad of the foreign investor's share of profit, shall be paid for from their hard currency earnings from the given type of activity, and also from other sources of obtaining foreign currency permitted by legislation. Operations with foreign currency shall be transacted by enterprises with foreign investments in accordance with the procedure stipulated by the legislation in force on RSFSR territory.

ARTICLE 27. INSURANCE OF ASSETS AND INSURANCE AGAINST RISKS

The insurance of the assets of an enterprise with foreign investments and insurance against risks shall be effected at its own discretion, unless otherwise stipulated by the legislation in force on RSFSR territory.

ARTICLE 28. TAXATION

Enterprises with foreign investments and also foreign investors shall pay taxes established by the legislation in force on RSFSR territory.

Taxation benefits may be established for enterprises with foreign investments operating in priority sectors of the national economy and in some particular regions.

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ARTICLE 29. AUDITING FOR PURPOSES OF TAXATION

Auditing for the purpose of taxing the financial and commercial activity of enterprises with foreign investments shall be carried out by auditing organisations of the RSFSR.

ARTICLE 30. BOOK-KEEPING ACCOUNTS AND REPORTS

The accounts and reports of enterprises with foreign investments on RSFSR territory shall be kept according to the rules in force in the foreign investor's country of origin.

For the purpose of balance sheet assessment and accounting, an enterprise with foreign investments shall convert its hard currency into roubles according to the rate used by the State Bank of the USSR in its foreign economic transactions.

ARTICLE 31. SECURITY FOR OBLIGATIONS

The assets of an enterprise with foreign investments may be used as security for all types of its obligations, including the attraction of loans. Its rights of ownership of buildings, structures and equipment, and other property rights, may serve as security for obligations.

Mortgaged assets or property rights may be sold by the mortgagee for roubles or foreign currency at contractual prices, including at auctions, to legal entities and citizens of the RSFSR, and in the cases provided for by legislative acts in force in the RSFSR, and also to foreign legal entities and natural persons and their associations.

ARTICLE 32. RIGHTS TO INTELLECTUAL PROPERTY

1. The protection and execution of rights to the intellectual property of enterprises with foreign investments shall be guaranteed in accordance with the legislation in force on RSFSR territory.

Enterprises with foreign investments shall conclude with their employees contracts in regard to the rights to objects of intellectual property created in keeping with the assignments confirmed by the enterprises' documents.

2. Patents for an invention, industrial sample and a trade mark shall be issued to an enterprise on concluding the relevant contract between the employee and the enterprise. This contract, in addition to transferring to the enterprise the employee's right to a patent, shall specify the enterprise's reciprocal duties to provide material, production and social conditions for the employee. Where the said contract between the employee and the enterprise with foreign investments has not been concluded, the patent shall be issued to the author of the invention or the industrial or commodity sample. The enterprise shall have the right to use this invention, industrial sample or trade mark on the terms stipulated by the contract concluded with the inventor holding the patent.

3. An enterprise with foreign investments shall take independent decisions on patenting abroad inventions and industrial samples belonging to it.

ARTICLE 33. LABOUR RELATIONS

1. Labour relations, including questions of hire and dismissal, work and recreation regime, terms of remuneration, guarantees and compensations at an enterprise with foreign investment shall be regulated by collective agreement (contract) and by individual labour agreements (contracts).

The terms of collective and individual labour agreements (contracts) must not worsen the conditions of the enterprise's employees compared with the terms stipulated by the legislation in force on RSFSR territory.

2. Aliens may be employees of enterprises with foreign investments and members of their management bodies. The terms of hire, work and rest and recreation and also the pension provisions for foreign employees shall be agreed upon in labour agreement (contract) concluded with each of them individually. The wages received in hard currency by foreign employees may be transferred by them abroad after payment of income tax.

3. Trade unions at enterprises with foreign investments shall conduct their activity on the basis of the legislation in force on RSFSR territory.

ARTICLE 34. SOCIAL INSURANCE AND SECURITY FOR EMPLOYEES OF ENTERPRISES WITH FOREIGN INVESTMENTS

1. Social insurance for workers at enterprises with foreign investments and their social security (with the exception of the pension scheme for foreign employees) shall be regulated by the legal norms of the legislation in force on RSFSR territory.

2. Payments for the pension schemes for foreign employees at enterprises with foreign investments shall be remitted to the respective funds in the countries of their permanent residence in currency and under the terms of these countries.

Enterprises with foreign investments shall make deductions for the state social insurance of Soviet and foreign employees and deductions for the pension schemes of Soviet employees according to the rates established for enterprises and organisations in the RSFSR.

CHAPTER V. ACQUISITION BY FOREIGN INVESTORS OF EQUITY IN ENTERPRISES, SHARES AND OTHER SECURITIES

ARTICLE 35. ACQUISITION BY FOREIGN INVESTORS OF EQUITY, STOCKS, SHARES AND OTHER SECURITIES OF ENTERPRISES

1. Foreign investors shall have the right to acquire equity, stocks, shares and other securities of enterprises situated on RSFSR territory. Equity, stocks and shares in enterprises may be purchased by foreign investors for USSR currency received as income from sources on the territory of the RSFSR and other Union republics, as well as for foreign currency. In the latter case, the foreign currency shall be converted into roubles according to the rate of exchange used by the State Bank of the USSR in its foreign economic transactions.

A foreign investor shall not use USSR currency, bought at a rate of exchange higher than the rate used by the USSR State Bank in its foreign economic transactions, to acquire equity, stocks, shares and other securities.

2. Where payment for equity, stocks, shares in an enterprise is made by the foreign investor in foreign currency, this enterprise shall be regarded as an enterprise with foreign investments. Where payment is made in USSR currency, the enterprise shall be regarded as an enterprise with foreign investments provided the foreign investor owns in it more than 50 per cent of equity, stocks, shares. In this case, the enterprise shall enjoy the privileges provided for in Article 25 of the present Law.

3. The acquisition by foreign investors of equity, stocks, shares and other securities shall be subject to registration at the RSFSR Ministry of Finance or other authorised state bodies.

4. The acquisition by foreign investors of shares and other securities at stock exchanges shall be regulated by the legislative acts of the RSFSR on stock exchanges and exchange transactions.

ARTICLE 36. ACQUISITION BY FOREIGN INVESTORS OF STATE-ISSUED SECURITIES

Foreign investors may acquire state-issued securities with the permission of the Ministry of Finance of the RSFSR or central financial bodies or the republics within the RSFSR.

ARTICLE 37. PARTICIPATION OF FOREIGN INVESTORS IN PRIVATISATION

1. Foreign investors may participate in the privatisation of state/municipally-owned enterprises, and also uncompleted projects of capital construction on RSFSR territory. The terms of their participation in competitions and auction sales for the privatisation of state/municipally-owned enterprises shall be defined by the legislation in force on RSFSR territory.

Payment for the acquired enterprises or equity, stocks, shares shall be made in USSR currency.

2. For the purpose of privatisation foreign investors may use the rouble funds in their settlement accounts obtained as income from sources on the territory of the RSFSR and other Union republics.

A foreign investor shall not use USSR currency, bought at a rate higher than the rate used by the USSR State Bank in its foreign economic transactions for purposes of privatisation.

Foreign investors may exchange their hard currency funds for USSR currency at the rate used by the USSR State Bank in its foreign economic transactions, and place them in special accounts at the Central Bank of the RSFSR and other authorised banks. Funds from the said accounts may be spent only for the purpose of privatisation. Foreign investors shall have the right to convert the remaining funds in these accounts back into foreign currency.

CHAPTER VI. ACQUISITION BY FOREIGN INVESTORS AND ENTERPRISES WITH FOREIGN INVESTMENTS OF RIGHTS TO USE LAND AND OTHER PROPERTY RIGHTS

ARTICLE 38. THE RIGHT TO USE LAND AND NATURAL RESOURCES

The granting to foreign investors and enterprises with foreign investments of rights to use land, including its lease, and natural resources shall be regulated by the Land Code of the RSFSR and other legislative acts in force on RSFSR territory.

ARTICLE 39. LEASING OF PROPERTY

Property shall be leased to foreign investors and enterprises with foreign investments on the basis of lease-hold agreements in accordance with the legislation in force on RSFSR territory.

Property which is the property of the RSFSR and costs more than 100 million roubles shall be leased with the permission of the state body authorised to manage this property.

ARTICLE 40. CONCESSION AGREEMENTS

1. The granting to foreign investors of rights to develop and exploit renewable and non-renewable natural resources and to conduct economic activity connected with the use of objects which are state property (but have not been transferred to the full economic or operational management of enterprises, institutions and organisations) shall be based on concession agreements concluded with the foreign investors by the RSFSR Council of Ministers or other authorised state body in accordance with the procedure laid down by the RSFSR legislation on concessions.

The duration of a concession agreement shall depend on the nature and terms of the concession, but may not be more than 50 years.

Unilateral alteration of the terms of a concession agreement shall not be permitted, unless otherwise stipulated by the agreement.

2. Concession agreements may contain clauses taken from the legislation in force on RSFSR territory. In this case they are subject to endorsement by the RSFSR Supreme Soviet.

CHAPTER VII. FOREIGN INVESTMENTS IN FREE ECONOMIC ZONES

ARTICLE 41. FREE ECONOMIC ZONES

Free economic zones shall be set up in the RSFSR in order to attract foreign capital, advanced technologies and managerial know-how from other countries and develop the republic's export potential. A preferential regime of economic activity, compared with the general one, shall be established in free economic zones for foreign investors and enterprises with foreign investments.

ARTICLE 42. CONDITIONS OF ECONOMIC ACTIVITY FOR FOREIGN INVESTORS AND ENTERPRISES WITH FOREIGN INVESTMENTS IN FREE ECONOMIC ZONES

1. Foreign investors and enterprises with foreign investments engaging in economic activity in free economic zones shall be granted, apart from the rights and guarantees provided for by the legislation in force on RSFSR territory, the following additional benefits:

- a simplified procedure for the registration of enterprises with foreign investments; enterprises with foreign investments of up to 75 million roubles shall be subject to registration with the authorised bodies directly in the economic zone;

- a preferential taxation regime: foreign investors and enterprises with foreign investments shall be taxed at reduced rates; this shall also apply to the tax on the portion of the profit repatriated. The tax rates may not be less than 50 per cent of the rates effective on RSFSR territory and applicable to foreign investors and enterprises with foreign investments;

- reduced rates of payment for the use of land and other natural resources; the granting of rights to long term lease for a period of up to 70 years with sub-leasing rights;

- a special customs regime that includes reduced customs duties on the import and export of goods; simplified formalities for cross-border trips;

- simplified formalities for granting entry and exit visas to aliens, and also entry without visa and exits.

2. The types and amounts of benefits granted in free economic zones shall be established by the RSFSR Council of Ministers and endorsed by the RSFSR Supreme Soviet.

RESOLUTION OF THE RSFSR SUPREME SOVIET ON THE ENFORCEMENT OF THE RSFSR LAW "ON FOREIGN INVESTMENTS IN THE RSFSR"

The Supreme Soviet of the RSFSR hereby resolves:

1. To enforce the RSFSR Law "On Foreign Investments in the RSFSR" as from September 1991.

2. To charge the Committee of the RSFSR Supreme Soviet for International Affairs and Foreign-Economic Relations, jointly with the RSFSR Council of Ministers, to draw up and submit to the RSFSR Supreme Soviet a draft Law of the RSFSR "On Concessions" prior to November 1, 1991.

3. All concession agreements shall be subject to endorsement by the RSFSR Supreme Soviet pending the adoption of the RSFSR Law "On Concessions".

4. The RSFSR Council of Ministers shall, prior to September 1:

- bring into conformity with this Law the resolutions and directives of the RSFSR Council of Ministers, and also ensure that the ministries, state committees and departments of the RSFSR revise or repeal their normative acts, including instructions that contradict this Law;

- resolve the question of the operation on RSFSR territory of the USSR Government's resolutions and directives where they contradict this Law.

5. The Central Bank of the RSFSR shall, prior to September 1, issue normative acts in execution of the RSFSR Law "On Foreign Investments in the RSFSR".

DECREE

OF THE PRESIDENT OF THE RUSSIAN FEDERATION

On the State Program of Privatization of State and Municipal Enterprises in the Russian Federation

For the purposes of deepening economic reforms and ensuring the stability of the legal bases for the single market of objects of privatization in the Russian Federation and in accordance with points 2 and 3 of Decree of the President of the Russian Federation No. 1598 of 7 October 1993 "On Legal Regulation in the Period of Phased Constitutional Reform in the Russian Federation," I hereby decree:

1. That the State Program of Privatization of State and Municipal Enterprises in the Russian Federation presented by the Council of Ministers - Government of the Russian Federation be ratified and put into effect from 1 January 1994.

2. That the Council of Ministers - Government of the Russian Federation shall:

by 25 January 1994 prepare proposals for the introduction of appropriate changes and supplements to the current legislation of the Russian Federation concerning taxation;

by 25 January 1994 prepare a Register of Stock-Issuing Enterprises and publish this Register in order to ensure the right of Russian citizens to use their privatization vouchers;

by 1 February 1994 bring previously issued regulatory acts into compliance with the State Program of Privatization of State and Municipal Enterprises in the Russian Federation;

by 1 March 1994 prepare regulatory acts ensuring execution of the State Program of Privatization of State and Municipal Enterprises in the Russian Federation;

by 1 March 1994 prepare drafts of Laws of the Russian Federation "On the Privatization of State and Municipal Educational Institutions" and "On the Privatization of Public Health Institutions and Pharmaceutical Institutions and Enterprises";

by 1 March 1994 develop a draft of a law of the Russian Federation on the transformation of state enterprises into public works (factories, institutes, and other organizations) financed directly from budgetary funds;

by 1 March 1994 develop and ratify Regulations on the Procedure for Use of Objects and Property of Civil Defense by Privatized Enterprises, Institutions, and Organizations.

3. That the State Committee of the Russian Federation for the Management of State Property, together with the State Committee of the Russian Federation for Issues of Architecture and Construction and the Ministry of Culture of the Russian Federation, shall by 1 March 1994 develop a Model Protective Contract applicable to the privatization of unoccupied premises located in buildings that are historical or cultural landmarks.

4. That it is established that the procedures installed by Decree of the President of the Russian Federation No. 1662 of 19 October 1993 "On Improving Bookkeeping and Increasing Accountability for its Timely Execution" apply to enterprises in which the share of state ownership, at the issuance of Decree of the President of the Russian Federation No. 1662 of 19 October 1993, constituted less than 25 percent.

5. That the commission of Securities and Stock Exchanges under the President of the Russian Federation shall within a two-month period ratify both a unified form for a qualification certificate granting the right to carry out operations with securities and also the procedure for issuing such a certificate.

6. That the State Committee of the Russian Federation for the Management of State Property and the territorial property management committees shall carry out the necessary work to compile a listing, using state budgetary funds, of the property of non-state organizations (trade unions, the former DOSAAF, consumer cooperatives) no later than 1 July 1994.

7. That the following decisions of the Supreme Soviet of the Russian Federation, which are directed towards the curtailment of the process of privatization in the Russian Federation, are declared inactive:

Resolution of the Presidium of the Supreme Soviet of the Russian Federation No. 2626-1 of 30 March 1992 "On the Legal Succession of the Russian Federal Property Fund with Regard to the Share of Ownership of the State Structures of the Former USSR";

subpoint (a) of point 1 of Resolution of the Supreme Soviet of the Russian Federation No. 5475-1 of 21 July 1993 "On the Introduction of Changes and Supplements to Resolution of the Supreme Soviet of the Russian Federation No. 3020-1 of 27 December 1991 'On the Delimitation of State Ownership in the Russian Federation to Federal Ownership, State Ownership by Republics within the Russian Federation, Krais, Oblasts, the Autonomous Oblast, Autonomous Okrugs, and the Cities of Moscow and St. Petersburg, and Municipal Ownership.'"

8. That the state administrative bodies and authorities of republics within the Russian Federation, the autonomous oblast, autonomous okrugs, krais, oblasts, and the cities of Moscow and St. Petersburg and the appropriate property management committees shall bring republic and local privatization programs into compliance with the State Program of Privatization of State and Municipal Enterprises in the Russian Federation within two months of publication of the latter.

9. That the State Committee of the Russian Federation for Statistics, together with the State Committee of the Russian Federation for the Management of State Property, shall within a three-month period develop a procedure and forms for the presentation of statistical accounting of privatization by enterprises.

10. That the State Program of Privatization of State and Municipal Enterprises in the Russian Federation be published.

11. That the present Decree be submitted for consideration by the Federal Assembly of the Russian Federation.

12. That the present Decree goes into effect from the moment of its signing.

President of the Russian Federation B. Yeltsin

Moscow, The Kremlin
24 December 1993
No. 2284

THE STATE PROGRAM OF PRIVATIZATION OF MUNICIPAL ENTERPRISES IN THE RUSSIAN FEDERATION

1. INTRODUCTION

The State Program of Privatization of State and Municipal Enterprises in the Russian Federation (hereinafter referred to as the Program) is a federal program in the economic and social development of the Russian Federation developed in accordance with the requirements of the Law of the Russian Federation "On the Privatization of State and Municipal Enterprises in the Russian Federation" taking into account the experience and results of the implementation of privatization in 1992-1993.

The Program establishes the goals, targets, priorities, restrictions, and procedure of privatization.

A broad construction of the restrictions on privatization that are indicated in the Program and also in local privatizaiton programs is not permitted.

The principal objectives of the Program are:

to form a broad stratum of private owners as an economic basis for market relations;

to involve the broadest possible strata of the population in the process of privatization through the sale of state and municipal property being privatized for privatization vouchers in specialized voucher auctions before 1 July 1994, and for money in auctions after 1 July 1994;

to complete privatization with the use of privatization vouchers;

to complete privatization of the majority of objects of "small privatization" and, on the basis of this, to accelerate the development of the commerce and services sphere;

to complete, for the most part, privatization of large- and medium-scale enterprises of industry and construction;

to heighten the efficiency of the activity of enterprises and of the national economy as a whole by implementing economic restructuring, developing post-privatization support for enterprises, creating a competitive environment, and developing a secondary market;

to attract investments into manufacture, including foreign investments;

to assist in the implementation of measures for social welfare, including protection of the rights of private owners (stockholders).

Federally-, state-, and municipally-owned objects and enterprises, based on the possibility of their privatization, can be assigned to the following groups:

federally-owned objects and enterprises whose privatization is prohibited:

federally-owned objects and enterprises that can be privatized only by a decision of the Government of the Russian Federation;

federally-owned objects and enterprises that can be privatized only by a decision of the State Committee of the Russian Federation for the Management of State Property (hereinafter the GKI of Russia) taking into account the opinion of sectoral ministries;

state/municipally-owned objects and enterprises that can be privatized in accordance with the Program only by a decision of state administrative bodies and authorities of republics within the Russian Federation, krais, oblasts, the autonomous oblast, autonomous okrugs, and the cities of Moscow and St. Petersburg and in accordance with local privatization programs;

federally- and state/municipally-owned objects and enterprises that are subject to mandatory privatization.

Federally- and state/municipally-owned objects that are not included in targets and not subject to privatization-related restrictions can be privatized on the basis of decisions of territorial property management committees or privatization applications submitted by any

individual.

When an application for privatization of an enterprise is submitted by a work collective or by any other outside physical or legal person acknowledged by the buyer in the process of privatization, the appropriate property management committee shall be obliged both to make a decision on privatization of the enterprise and to notify the applicant of this decision.

Privatization of state and municipal educational institutions shall be regulated by the corresponding legislation.

Public health institutions and enterprises, and also pharmaceutical institutions, pending the passage of a law or other legislative act of the Russian Federation, shall be privatized by a special procedure established by the Government of the Russian Federation.

Issues concerning the privatization of objects owned by republics within the Russian Federation, krais, oblasts, the autonomous oblast, autonomous okrugs, or the cities of Moscow and St. Petersburg, and also those concerning the privatization of municipally-owned objects, shall be decided by subjects of the Federation based on the legislation of the Russian Federation on privatization, including features, restrictions, and principles determined by the current Program.

The requirements established by the Program shall be binding for federal authorities, state administrative bodies, and authorities of republics within the Russian Federation, krais, oblasts, the autonomous oblast, autonomous okrugs, and the cities of Moscow and St. Petersburg, as well as for local self-governing bodies.

2. CLASSIFICATION OF OBJECTS AND ENTERPRISES BASED ON THE POSSIBILITY OF PRIVATIZATION THEREOF

2.1 FEDERALLY-OWNED OBJECTS AND ENTERPRISES WHOSE PRIVATIZATION IS PROHIBITED

2.1.1 Mineral, forest, and water resources, airspace, resources of the continental shelf, territorial waters, and maritime economic zone of the Russian Federation, as well as the communication and orbiting capabilities of satellites.

2.1.2 Natural territories that are protected or reserved for special use and the real estate located in these territories.

2.1.3 Funds of the republican budget of the Russian Federation, the Republican Currency Reserve of the Russian Federation, the Pension Fund of the Russian Federation, the Fund for Social Security, Employment, and Social Support of the Population of the Russian Federation, other state extra-budgetary funds, and the Central Bank of the Russian Federation, including the Diamond Fund of the Russian Federation and the Gold Reserve of the Russian Federation.

2.1.4 The Central Bank of the Russian Federation and the enterprises ensuring the issue and storage of banknotes, state treasury notes, bonds, and other state securities.

2.1.5 Permanent or issued military and nonmilitary property (including arsenals) under the operational command of the Armed Forces of the Russian Federation, the Federal Counterintelligence Service of the Russian Federation, the Ministry of Defense of the Russian Federation, the Ministry of the Interior of the Russian Federation, the Federal Agency of Government Communications and Information under the President of the Russian Federation, the troops of the aforementioned branches, and other ministries and departments having military units, as well as the property of defense industry boards and troop detachments of

the Federal Bureau of Special Construction under the Government of the Russian Federation and the Federal Special Bureau for Construction in the Eastern Raions of the Russian Federation under the State Committee of the Russian Federation for Issues of Architecture and Construction. Special sites for testing of weapons and military hardware.

2.1.6 Institutions and organizations that receive more than 50 percent of their financing from the republican budget of the Russian Federation.

2.1.7 Chattel and real estate of historical and cultural significance from a list approved by the Government of the Russian Federation.

2.1.8 Enterprises and objects of the hydrogeological service of the Ministry of Public Health of the Russian Federation, services for environmental monitoring and environmental protection, including regional institutes and enterprises of the Russian Scientific Research and Planning/Surveying Association for the Use of Land, the All-Russian Institute of Agricultural Aerophotogeophysical Investigation with its regional branches, the Russian Center for Scientific Land Reform, and the Russian Institute of Soil and Ecosystem Monitoring with its regional institutes.

2.1.9 Enterprises, organizations, and objects in the scientific and technical sphere of the state health and epidemiological services of the Russian Federation, veterinary services, crop protection services, resources for protection and breeding of endangered species, and also nurseries for laboratory animals.

2.1.10 Hydroeconomic and meliorative systems and structures, organizations for supervision of the meliorative condition of soil.

2.1.11 Railroads and objects and property of rail transport directly participating in the delivery process and in emergency restoration work.

2.1.12 Enterprises manufacturing state insignia.

2.1.13 Enterprises and objects in the scientific and technical sphere involved in the development, production, and sale of narcotic substances, and also in the planting, cultivation, and processing of crops bearing narcotic substances, including enterprises for the processing of hemp.

2.1.14 Port hydrotechnical structures and objects, including those servicing the Northern Maritime Route and nuclear, academic, hydrographic, and ice-breaking fleets, property for carrying out rescue work and fighting oil spills at sea, objects and structures for managing naval traffic and inspecting port supervision, the Atomflot repair and technology enterprise, property of associations for the construction of waterways and canals, property owned by detachments of the Underwater River Construction Agency and by shipping inspectorates.

2.1.15 Organizations and objects of naval emergency rescue services and radionavigational and technological communications for sea and river transport.

2.1.16 Objects, enterprises, and equipment for burial of solid and liquid radioactive and toxic chemical waste, burial grounds for animal refuse.

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2.1.17 Objects and enterprises of the Ministry of the Interior of the Russian Federation, the Federal Counterintelligence Service of the Russian Federation, the Ministry of Defense of the Russian Federation, and the State Customs Committee of the Russian Federation, and also enterprises created to ensure the operation of federal government bodies and authorities of the Russian Federation and Border Troops of the Russian Federation.

2.1.18 Nuclear installations and enterprises for the production of special nuclear and radioactive materials and nuclear weapons, and also enterprise performing scientific research and development work in the indicated areas.

2.1.19 Stationary objects of social services, including orphanages, nurseries, the Scientific Research Institute of Prosthetics and Prosthesis Development, the Scientific Research Institute for the Determination of the Ability to Work and the Organization of the Work of Invalids, the institute for the advanced training of doctors and specialists, and territorial centers of social services, and also boarding schools for orphans and children without guardians, boarding schools for children with deficiencies in intellectual and physical development, homes for the elderly, nursing homes, dormitories, hospitals, sanatoria, boarding houses for invalids, children and the elderly, prosthetic and orthopedic enterprises, including scientific research institutes in the areas of prosthetics and orthopedics involved in the production of products and the provision of services to invalids with impaired motor ability.

2.1.20 Objects, enterprises, systems, and funds for air-traffic control and enterprises involved in the provision of a unified system of air-traffic control in both lower and upper airspace; airfields of federal importance (classes A,B,C,D, and E in accordance with the adopted classification), meteorological centers and test-flight stations, training centers of civil aeronautics.

2.1.21 Objects and enterprises whose security is ensured by closed administrative and territorial units (from a list approved by the Government of the Russian Federation).

2.1.22 State seed inspection centers, breeding and hybridizing centers, laboratories for strain testing of agricultural crops, strain testing stations and plots, flaxseed culture and hempseed culture stations, planning and surveying centers and stations for agrochemical services, centers for chemizations and agricultural radiology, farms for production of valuable and anadromous species of fish, reservoir operations for the protection and reproduction of fish populations, state fish hatcheries and farms, state stables and racetracks of federal importance, and nurseries for laboratory animals.

2.1.23 Stocks of the state reserve, bases of the Committee of the Russian Federation for State Reserves and other objects of same intended for the storage and maintenance of the financial assets of the state reserve, and also mobilization reserves (with the exception of such property of reserves as meets the specifications given in the model agreement established by the GKI of Russia in conjunction with the Ministry of Defense of Russia and the Ministry of the Economy of Russia).

2.1.24 Objects and enterprises of the Federal Postal Service under the Ministry of Communications of the Russian Federation.

2.1.25 Objects and enterprises within the jurisdiction of the State Committee of the Russian Federation for Statistics.

2.1.26 The Insurance Fund of Technical Documentation.

2.1.27 Organs of scientific and technical information, scientific and technical libraries that gather, process, store, and offer access to state informational resources on the scientific and technical development of Russia, state archives and funds.

2.1.28 Enterprises and objects of the Federal Bureau of Russia for Hydrometeorology and Monitoring of the Environment and the Federal Bureau of Russia for Geodesy and Cartography that help ensure the standardization of the technological process of observation and information preparation.

2.1.29 Objects and enterprises under the auspices of the Federal Agency for Medical-Biological and Extremal Problems under the Ministry of Public Health of the Russian Federation.

2.1.30 Militarization and mine-rescue units, services and specialized subdivisions providing defense against gas and oil outflows, including those responding to emergency situations, natural disasters, and nuclear disasters.

2.1.31 Objects of amateur and professional sports used for the training of national teams.

2.1.32 Objects and enterprises for the extraction of precious stones, refining factories (mills and plants).

2.1.33 Enterprises and objects in the scientific and industrial-development sphere under the auspices of the Russian Academy of Sciences, the Russian Academy of Agricultural Sciences, the Russian Academy of Medical Sciences, the Russian Academy of Education, and the Russian Academy of Arts imparted to same by the procedure established by decree of the President of the Russian Federation (from a list approved by the Council of Ministers - Government of the Russian Federation).

2.1.34 Television broadcasting centers, radio centers (including technical facilities and structures, except those that are the property of enterprises subject to privatization).

2.1.35 Enterprises involved in the development and manufacture of encoding technology.

2.1.36 Objects in the scientific and technical sphere engaged in research into environmental protection and ecological monitoring under the Ministry for the Protection of the Environment and Natural Resources of the Russian Federation.

2.1.37 Protected objects of state administrative bodies, protective structures of civil defense, type two financial assets and special independent warehouses for their storage.

2.1.38 Federal highways for public use and organizations for their upkeep.

2.1.39 Objects in the nonindustrial sphere under the jurisdiction of federal representative bodies.

2.1.40 Objects and enterprises for the development and manufacture of

immunobiological compounds under the jurisdiction of the Ministry of Public Health of the Russian Federation.

2.1.41 Institutes for training the personnel of sectoral ministries and departments.

2.1.42 Crematoria and cemeteries.

2.1.43 Enterprises, objects, and organizations of geological services engaged in regional geological research related to state defensive needs and work on the continental shelf and within the boundaries of the maritime economic zone and in international waters, including naval vessels intended for this work, and also enterprises, objects, and organizations engaged in fundamental scientific research and development work directed towards resolutions of federal programs for the development of the national mineral and raw material base, corresponding to a special list approved by a Decree of the President of the Russian Federation, deep drilling wells located within the boundaries of mining areas or within areas in which licenses are issued to mining or other enterprises, and the state network of supervisory wells and observation points for oil gushers and gas springs.

2.1.44 The subway

Note: By decision of the Government of the Russian Federation, for enterprises listed in section 2.1, the privatization of independent production not connected to the output of specifically proscribed goods may be allowed.

2.2 FEDERALLY-OWNED OBJECTS AND ENTERPRISES THAT CAN BE PRIVATIZED ONLY BY A DECISION OF THE GOVERNMENT OF THE RUSSIAN FEDERATION

2.2.1 Objects and enterprises producing and repairing any weapons systems and components, including coupling devices and military hardware not suitable for other applications, those manufacturing spacecraft, military supplies, explosives, fireworks, and special chemicals, and also objects engaged in research and development in the above fields (except those specified in 2.1).

2.2.2 Objects of civil defense (except those specified in 2.1).

2.2.3 Special refrigerators designed for the permanent housing of state reserves, the accumulation of a federal food stock, and the storage of mobilization reserves (except those specified in 2.1).

2.2.4 Objects and enterprises processing precious metal ores, precious and semiprecious stones, and radioactive and rare-earth elements (except those specified in 2.1).

2.2.5 Enterprises and associations of the fuel and energy complex (with the exception of organizations and enterprises in the construction industry), including enterprises involved in electric power, coal, oil, and gas extraction and processing, oil geophysics, and the manufacture of petroleum products, as well as nuclear power plants and objects and enterprises of pipeline transport.

2.2.6 Enterprises and objects of rail transport, enterprises of sea and air transport of federal importance (except those specified in 2.1 and 2.4).

2.2.7 The scientific research fleet for the regulation of prospecting in the fish industry, fishing ports.

2.2.8 Commercial banks (to be privatized in accordance with a special procedure established by the Government of the Russian Federation based on the consulting opinion of the GKI of Russia, the Ministry of Finance of Russia, and the Ministry of the Economy of Russia).

2.2.9 Communications enterprises (except those within the "Rospechat" retail network and those specified in 2.1), including scientific research and planning and design enterprises and organizations, their enterprises for experimentation and testing, and also institutions of the Committee of the Russian Federation for Information Dissemination.

2.2.10 News agencies and television and radio broadcasting companies.

2.2.11 Objects and enterprises of sociocultural importance (including theaters, cinemas, concert and exhibition halls, movie studios and film-printing facilities, and objects of amateur and professional sports).

2.2.12 Foreign trade associations of the Ministry of Foreign Economic Affairs of the Russian Federation and of other ministries and departments of the Russian Federation, if others are not established by the legislation of the Russian Federation.

2.2.13 Objects and enterprises conducting operation and maintenance in the gas industry having general Russian and interregional importance.

2.2.14 Chattel and real estate of historical and cultural significance (except those specified in 2.1) entrusted to the state and also held in the collections of state and municipal museums, archives, libraries, and galleries, and in the showrooms of enterprises in the art industry and in the traditional folk trades, including the premises and buildings where they are located.

2.2.15 Printing enterprises, publishers, and book wholesalers under the jurisdiction of the Committee of the Russian Federation for Printing, the Ministry for Social Welfare of the Russian Federation and the Ministry of Public Health of the Russian Federation.

2.2.16 Enterprises and objects in the scientific and technical sphere under the auspices of the Committee of the Russian Federation for Standardization, Weights and Measures, and Certification, machine testing stations.

2.2.17 State-owned sanatoria and resorts under the jurisdiction of the Ministry for Social Welfare of the Russian Federation and the Ministry of Public Health of the Russian Federation.

2.2.18 Enterprises and objects of the Republican (Federal) Fund for Social Support.

2.2.19 Enterprises in the lumber industry, bases for airborne forest protection, and also objects in the scientific and technical sphere under the auspices of the Russian forest protection services.

2.2.20 Enterprises and objects under the auspices of the Committee for the Water

industry under the Government of the Russian Federation.

2.2.21 Disengaged chattel and real estate (with the exception of arms and ammunition) under the operational command of the Armed Forces of the Russian Federation, the Federal Counterintelligence Service of the Russian Federation, the Ministry of Defense of the Russian Federation, the Ministry of the Interior of the Russian Federation, the Federal Agency of Government Communications and Information under the President of the Russian Federation, the troops of the aforementioned bodies, and other ministries and departments having military units, as well as enterprises and objects of these ministries and departments not involved in the production or repair of weapons systems and components or the production of ammunition, explosives, or fireworks (except those specified in 2.1 and enterprises of the Federal Counterintelligence Service of the Russian Federation).

2.2.22 Enterprises for the production of special nonnuclear materials.

2.2.23 Enterprises of geological services (except those specified in 2.1.

2.2.24 Objects and enterprises of the medical industry. pharmaceutical bases (storehouses) and bases of medical technology that supply commodities for federal and state needs, and also those servicing raions in the Far North and similar raions (except those specified in 2.1).

2.2.25 Scientific and technical enterprises and objects of the chemical complex performing technical operations with toxic substances of the first and second danger classes, and also manufacturers rated as first level explosive hazards.

2.2.26 Objects whose construction is financed from the federal budget (except those specified in 2.5).

2.2.27 Objects and enterprises of the mining industry having general federal importance, including salt mining (with the exception of enterprises mining local raw materials, and also those performing logging activity, including those extracting tar-impregnated wood, resin, and barras).

2.2.28 Enterprises for the burial of solid industrial and everyday waste.

2.2.29 Enterprises and organizations within the jurisdiction of the Committee of the Russian Federation for Patents and Trademarks.

2.2.30 Livestock and horse breeding centers, livestock farms, enterprises of livestock services.

2.2.31 Auxiliary-production agricultural facilities of the biological industry, the Sortsemovoshch enterprises of the Rossortsemovoshch Russian republican association.

2.2.32 State scientific centers from a list approved by the Government of the Russian Federation.

2.2.33 Specialized factories and manufacturers of intermediate products and nonstandardized equipment and instruments for prothesis and orthopedic enterprises.

2.2.34 Resources for the transportation of nuclear weapons.

2.2.35 Enterprises and objects of the Federal Bureau of Russia for Geodesy and Cartography (except those specified in 2.1).

2.2.36 Enterprises and organizations of the Federal Bureau of Employment of Russia that are financed from the State Fund for Employment of the Population of the Russian Federation.

2.3 FEDERALLY-OWNED OBJECTS AND ENTERPRISES THAT CAN BE PRIVATIZED ONLY BY A DECISION OF THE GKI OF RUSSIA TAKING INTO ACCOUNT THE OPINIONS OF SECTORAL MINISTRIES AND DEPARTMENTS

2.3.1 Enterprises of all branches of the national economy (not specified in 2.1 or 2.2) whose share in the federal market for certain products, work, or services exceeds 35 percent.

2.3.2 Large-scale enterprises having, as of 1 January 1992, a net value of fixed assets of greater than 1 million rubles.

2.3.3 Enterprises of sea and river transport (except those specified in 2.2).

2.3.4 Scientific research, design, planning and design, and planning and surveying institutes, objects, and experimental production objects (not specified in 2.1 or 2.2) having a net value of fixed assets, as of 1 January 1992, of greater than 1 million rubles.

2.3.5 Enterprises for the production, bottling, and packaging of alcoholic beverages and spirits, wine, and tobacco products.

2.3.6 Special enterprises for the production of baby food.

2.3.7 Enterprises and organizations connected with the feeding of passengers on ships and in railroad cars and stations, and also those supplying sea and river fleets.

2.3.8 Wholesale enterprises providing goods for federal and state needs, and also those serving raions of the Far North and similar regions, including temporary work settlements, as well as those serving the population of closed territories and administrative regions (except those specified in 2.2).

2.3.9 Printing enterprises and publishers (except those specified in 2.2).

2.3.10 Specialized construction organizations building objects providing state security (except those specified in 2.1 and 2.2).

2.3.11 Objects and enterprises whose construction and modernization is financed from the state budget and who operate in accordance with the federal nuclear disaster response program, and those situated in and outside evacuated areas, temporary residence areas for evacuees, and areas specified for social and economic disaster relief under the current legislation for territories subjected to radioactive contamination.

2.3.12 Objects and enterprises of nuclear machine building.

2.3.13 Enterprises and objects of the Federal Bureau of Russian for Hydrometeorology and Monitoring of the Environment (except those specified in 2.1)

2.3.14 Enterprises and objects of oil and gas industry construction.

2.3.15 Enterprises for the manufacture of construction materials and equipment whose output constitutes greater than 30 percent of the general output volume in the Russian Federation.

2.3.16 Enterprises producing specialized equipment for cultural institutions.

2.3.17 Circus enterprises and organizations that are part of the Russian Circus company.

2.3.18 Craft producers, small and large game hunting facilities, animal farms, ranches, and husbandry associations, state fur farms (fur farms).

2.3.19 Specialized elevators and warehouses for permanent housing of state reserves, the accumulation of a federal food stock, and the storage of mobilization reserves (except those specified in 2.1).

2.3.20 Objects and enterprises of the agrobiological industry and their auxiliary agricultural facilities under the auspices of the Ministry of Agriculture of the Russian Federation.

The procedure for making decisions on the privatization of objects and enterprises specified in 2.2 and 2.3.

Decisions on the privatization of enterprises specified in 2.2 and 2.3 shall be made on the basis of laws of the Russian Federation and acts of the President of the Russian Federation by the Government of the Russian Federation and the GKI of Russia and its territorial bodies.

Documents on the privatization of federally-owned enterprises shall be submitted to the property management committee empowered by the territorial representative of the GKI of Russia. The committee must, within three days, refer these documents:

if the enterprise is specified in 2.2, to the GKI of Russia, with copies sent to the relevant ministry, state committee, committee, or financial institution;

if the enterprise is specified in 2.3, to the financial institution for the area where the enterprise is located or registered, with copies sent to the relevant sectoral ministry, state committee, or committee.

Copies of the documents on privatization shall also be sent to the State Committee of the Russian Federation for Antitrust Policy and Support of New Economic Structures or to its territorial department for objects requiring the Committee's approval, which must, within three weeks, report its conclusions to the GKI of Russia (if the enterprise is specified in 2.2) or to the territorial agency of the GKI (if the enterprise is specified in 2.3).

Sectoral ministries, state committees, and committees must, within two weeks of receipt of documents, report their conclusions on the advisability of privatization of federally-owned objects to the body making the final decision on privatization.

For objects and enterprises specified in 2.3, the head of the territorial agency of the GKI of Russia, taking into account the conclusion of the relevant ministry, must make a decision on privatization within one month after the documents are sent to the sectoral

ministries and departments.

Upon expiration of the time allotted for the presentation of a nonfavorable response on privatization by the ministries, state committees, and committees, the appropriate head of the territorial agency of the GKI of Russia is obligated to make a decision on privatization.

If the territorial agency denies privatization, or if there is disagreement between the ministries and the territorial agencies on the issues of privatization of objects and enterprises specified in 2.3, then the GKI of Russia shall have the right to consider for itself the possibility of privatization, taking into account the opinion of sectoral ministries and departments.

For objects and enterprises specified in 2.2, the GKI of Russia, within 15 days of receipt of both the documents from the territorial agency and the conclusions from the ministries and departments, must submit drafts of directives to the Government of the Russian Federation.

The Government of the Russian Federation must, within 10 days (for enterprises of the military-industrial complex, within one month) of submission, consider the drafts of directives and make corresponding decisions.

If, in the time allotted the Government of the Russian Federation, no decisions are made by the established procedure, the GKI of Russia must, within one month of the expiration of the former period, make a decision on the possibility and procedure of privatization.

If the Government of the Russian Federation makes an unfavorable decision on privatization, the GKI must, in the same time frame, send a copy of the directive of the Government of the Russian Federation to the relevant territorial agency.

Upon considering the issues of privatization of objects and enterprises specified in 2.2 and 2.3, the Government of the Russian Federation and the GKI of Russia and its territorial agencies can make the following decisions:

1. To forbid privatization. In this case, one of the following decisions can be taken: to transform the enterprise into an open joint-stock company in accordance with Decree of the President of the Russian Federation No. 721 of 1 July 1992 "On Organizational Measures for Transforming State Enterprises and Charitable Organizations of State Enterprises into Joint-Stock Companies" with 100 percent of the shares held in state ownership, or to transform the enterprise into a state institution financed from the federal budget.

2. To establish restrictions on privatization exclusively by holding common (with voting privileges) share packages (51, 38, and 25.5 percent) in federal ownership or by issuing "Golden Shares" (Zolotye Aktsii).

3. To permit privatization without any type of restriction.

For the transformation of enterprises specified in 2.2 and 2.3 into joint-stock companies, the Government of the Russian Federation and the GKI of Russia shall determine the targets, conditions, and time limits for holding share packages and "Golden Shares" (Zolotye Aktsii) in federal ownership, taking into account the opinions of sectoral ministries and departments and state administrative bodies.

Share packages can be held in federal ownership for a period of no more than three years, and can only be held in the quantities of 51, 38, and 25.5 percent of the common (with voting privileges) shares as regards enterprises and organizations engaged in the following types of activity:

communications;

electric power generation and distribution;

extraction, processing, and sale of oil, natural gas, and gas concentrate;

extraction and processing of precious metals, precious stones, and radioactive and rare-earth elements;

development, production, and repair of arms, military hardware, and ammunition (including chemical and bacteriological);

production of alcoholic beverages and spirits;

enterprises directly involved in sea and air traffic, and also airports, and sea and river ports; patent service, standardization and weights and measures;

scientific and technical and planning and design enterprises; specialized enterprises for constructing and operating objects intended for national security; publishers and enterprises releasing printed material for state needs;

pipeline transport;

circus enterprises and organizations that are part of the Russian Circus company;

wholesale enterprises purchasing for state needs and import-export operations for the fulfillment of interstate agreements.

Share packages of privatizing enterprises in the indicated areas that are held in federal ownership for less than three years consist of common shares which, prior to either the deadline indicated in the privatization plan or a decision to sell them prematurely, are held in the relevant committee for the management of state property.

A decision to hold a share package consisting of 51 percent of the common (with voting privileges) shares can be taken only on the basis of a decree of the President of the Russian Federation. A decision to hold a share package consisting of 38 percent of the common (with voting privileges) shares can be taken by the Government of the Russian Federation.

For the transformation of enterprises into joint-stock companies whose controlling interest is held in federal ownership for up to three years, the Government of the Russian Federation and the GKI of Russia shall have the right, according to their jurisdiction as established by the State Program of Privatization of State and Municipal Enterprises of the Russian Federation, to commission, on a contractual basis, the representation of state interests in the board of directors of a joint-stock company by parties appointed by them, including those holding offices in state administrative bodies for the representation of relevant ministries, departments, and raions. Office-holders in state administrative bodies who are appointed to the boards of directors of joint-stock companies in accordance with the established procedure shall perform their duties on a gratuitous basis.

For the transformation of enterprises specified in 2.2 and 2.3 into joint-stock companies, the Government of the Russian Federation or the GKI of Russia, taking into account the suggestions of ministries and departments, can, upon issuing stock in these companies, make a decision to issue "Golden Shares" (Zolotye Aktsii) for a period of up to three years.

Simultaneous holding of "Golden Shares" (Zolotye Aktsii) and any other types of share packages in state ownership is not permitted.

When "Golden Shares" (Zolotye Aktsii) is issued, benefits for members of a work collective shall be granted in accordance with the procedure put forth in the Program.

The Government of the Russian Federation and the GKI of Russia shall have the right to make a decision to transfer share packages held in federal ownership into "Golden Shares" (Zolotye Aktsii).

Dividends of stocks held in federal or state ownership shall be completely channelled into the financing of objects for sociocultural and community-service purposes. These are objects which are either acquired, in the process of transforming an enterprise into a joint-stock company, into the assets of local authorities or which remain in the assets of the enterprise and are used for their original purposes. In the absence of such objects, dividends

[illegible] into the federal budget in accordance with the procedure set forth in the [illegible] determined by the Ministry of Finance of Russia with the consent of the GKI of Russia.

This procedure for the distribution of dividends can be changed only by decision of the Government of the Russian Federation.

The processes of separating state enterprises into groups, to which apply restrictions in accordance with 2.1 and 2.2, of making decisions to hold share packages in state ownership or to issue "Golden Shares" (Zolotye Aktsii), and also of representing state interests in the boards of directors of joint-stock companies by parties holding offices in state administrative bodies shall all be carried out in accordance with the Standards developed by the GKI of Russia and approved by the Government of the Russian Federation.

The fact that an enterprise possesses a defense contract constituting not greater than 30 percent of its general production, or that it is responsible for mobilization training, the protection of state secrets, or worker safety does not constitute a basis for holding any share packages in federal ownership upon the transformation of said enterprise into a joint-stock company.

Shares of an enterprise being privatized that are not held in federal ownership in accordance with 2.3 must be sold no later than four months after registration of the joint-stock company and are nonreservable.

2.4 STATE/MUNICIPALLY-OWNED OBJECTS AND ENTERPRISES THAT CAN BE PRIVATIZED IN ACCORDANCE WITH THE PROGRAM ONLY BY A DECISION OF STATE ADMINISTRATIVE BODIES AND AUTHORITIES OF REPUBLICS WITHIN THE RUSSIAN FEDERATION, KRAIS, OBLASTS, THE AUTONOMOUS Oblast, AUTONOMOUS OKRUGS, AND THE CITIES OF MOSCOW AND ST. PETERSBURG AND IN ACCORDANCE WITH LOCAL PRIVATIZATION PROGRAMS

2.4.1 Objects and enterprises of urban and suburban passenger transport, except taxis and enterprises for their repair.

2.4.2 Bath houses, laundries serving objects, enterprises, and institutions for sociocultural purposes (public health, education, culture, and sports).

2.4.3 Objects and enterprises for the offering of ritual services.

2.4.4 Garbage processing factories.

2.4.5 Pharmacies (with the required state operating licenses).

2.4.6 State/municipally-owned cultural objects and enterprises (including cinematography) and state/municipally-owned objects and enterprises of amateur and professional sports.

2.4.7 Property either in the assets of local governing and administrative bodies or ensuring their operation.

2.4.8 Objects in the engineering infrastructure of cities and raions (including electric, heat, and gas supply, water pipes, the sewer system, and public lighting), as well as enterprises operating, servicing, or maintaining the aforementioned objects.

2.4.9 Enterprises manufacturing products and performing work [illegible] in prosthetics including dental prosthetics, prosthesis construction, and orthopedic [illegible] (except those specified in 2.1).

2.4.10 State/municipally-owned organizations in the system of social welfare programs.

2.4.11 Children's country homes and youth camps, including those in the assets of enterprises being privatized.

2.4.12 Airports of regional and local importance.

2.4.13 Enterprises of regional social support funds, including those having under their authority objects in the sanatorium and health resort industry.

2.4.14 Wholesale enterprises serving remote arctic raions of the Far North, regions of the Far North, and similar regions with seasonally-restricted navigability, including temporary work settlements, settlements of geophysical and geological parties, and regions for the residence and economic activity of the sparse poulation of the North.

2.4.15 Enterprises of minor power production using the energy of minor rivers, the sun, the wind, and geothermal sources, enterprises working in autonomous energy production and not connected with a unified energy system, with the exception of atomic stations.

2.4.16 Sea ports of regional and local importance.

2.4.17 Highways for public use, enterprises and organizations for their upkeep (except those specified in 2.1).

Restrictions on privatization set by the Program are mandatory for all state governing and administrative bodies and bodies for local self-government. The introduction by these bodies of supplementary restrictions on the privatization of enterprises and state and municipal property and on the sale of state- and municipally-owned shares is prohibited.

The privatization of objects and enterprises subject to restrictions established by the Program is not permitted without the permission of the appropriate organs.

Buying and selling, transfer, and exchange of interests (shares or parts thereof and stock) is forbidden among legal persons whose charter capital (fund) is more than 25 percent state or municipal property.

2.5 OBJECTS AND ENTERPRISES THAT ARE SUBJECT TO MANDATORY PRIVATIZATION

The following objects and enterprises are subject to mandatory privatization:

2.5.1 Wholesale and retail objects and enterprises (including those for the sale of products with industrial and technical purposes), objects and enterprise of the food service industry and basic services, including bureaucratic objects of the retail trade, public food supply, and basic services networks (except those specified in 2.1 - 2.4).

2.5.2 Objects and enterprises (organizations) involved in construction and the construction materials industry (except those specified in 2.2 and 2.3).

2.5.3 Enterprises in the food-processing industry and in light industry.

2.5.4 Objects that are temporarily shut down and objects of uncompleted construction for which the regulatory construction periods have expired (with the exception of power blocks of nuclear plants).

2.5.5 Property of enterprises liquidated without establishing successorship.

2.5.6 Enterprises of automobile transport, including taxi services (except those specified in 2.4).

2.5.7 Enterprises subject to mandatory issuing of stock, determined by Decree of the President of the Russian Federation No. 721 of 1 July 1992.

2.5.8 Objects involved in commerce, the food-services industry, and basic services of the population, enterprises of the construction industry built with funds from the state and local budgets.

2.5.9 Debtor enterprises in all branches of the national economy (except those specified in 2.1).

2.5.10 Guest complexes, hotels, motels, campsites, and boarding houses (except those specified in 2.2 and those which are in the property aggregate of an enterprise).

2.5.11 Enterprises in the communal housing industry (except those specified in 2.4).

2.6 PRIVATIZATION OF LEASED OBJECTS OF NONRESIDENTIAL REAL ESTATE

Citizens engaged in entrepreneurial activity and enterprises whose charter capital consists of no more than 25 percent state/municipally owned interests (shares), in the case that they have entered into a lease agreement on a competitive or auction basis, as well as partnerships and joint-stock companies created in the process of privatization, have the right to acquire nonresidential premises, including both permanent and annexed premises, leased by them in residential buildings, and also to acquire buildings and structures owned by the Russian Federation (federally-owned), by republics within the Russian Federation, krais, oblasts, autonomous formations, and the cities of Moscow and St. Petersburg (state-owned), or by municipalities (municipally-owned).

The sale of leased objects of nonresidential real estate is carried out by the appropriate property management committee in response to an application by the lessee. Establishment of restrictions on the resale of acquired objects of nonresidential real estate is not permitted.

The sale of leased real estate (buildings, structures, and plots of land on which they are situated) or nonresidential premises, including both permanent and annexed premises, in residential buildings to lessees indicated in 2.6 can be denied only if restrictions specified in 2.1 apply to these objects, or in regard to buildings and structures that are real estate of historical and cultural importance, religious buildings, and buildings and structures occupied by state governing and administrative bodies and courts.

The price paid by lessees for buildings, structures, and plots of land on which they are

situated (the sale of which constitutes real estate), and also for nonresidential premises, including both permanent and annexed premises, in residential buildings, is determined by the procedure set forth in article 17 of the Law of the Russian Federation "On the Privatization of State and Municipal Enterprises in the Russian Federation."

Auctioned or competitive sale is permitted only in regard to vacant or unused objects of nonresidential real estate.

Assets originating from the sale of leased objects of nonresidential real estate are allocated in accordance with the regulations set forth by the Program.

3. CALCULATED PRIVATIZATION INDICES FOR STATE GOVERNMENTAL AND ADMINISTRATIVE BODIES

3.1 Proceeding from privatization targets, and also from the structure and extent of privatization demands in territorial and sectoral divisions, the GKI of Russia will establish calculated targets for share issuing and privatization of an ever increasing number of enterprises, and for the use of privatization vouchers, which shall be an integral part of the Program.

Calculated indices shall be distributed to regions within one month of the Program's adoption and shall be subject to quarterly adjustment by the GKI of Russia.

3.2 Based on the targets, property management committee of republics within the Russian Federation, krais, oblasts, the autonomous oblast, autonomous okrugs, and the cities of Moscow and St. Petersburg shall develop local privatization programs and shall make predictions of the quantity of privatization vouchers and money that will be received as a result of privatization. The local privatization programs adopted by the respective local governing bodies shall be presented to the GKI of Russia and to the Russian Fund for Federal Property.

4. ORGANIZATION AND ALLOCATION OF PROCEEDS FROM PRIVATIZATION

4.1 Proceeds from privatization shall be defined as all intake in the form of money and privatization vouchers resulting from the sale of objects of privatization, and all receipts during the process of population in the form of registration fees, collateral, and other receipts.

Neither dividends from shares belonging to the state nor royalties from the rental of state and municipal property are included in proceeds from privatization; they are thus subject to remittance into the appropriate budget, after deducting expenses incurred for banking operations (except in cases specified in 2.3 and 6).

4.2 The expected total receipts from privatization in 1994 are estimated at 0.7 trillion rubles in the form of privatization vouchers, and another 0.8 trillion rubles in cash.

The expected dividends from shares held in federal and state ownership in 1994 are estimated at 200 billion rubles.

4.3 Allocation of proceeds from privatization, including privatization vouchers, shall be conducted in accordance with regulations under Appendix 1 to the Program and in the following priority. Payments shall be made to: (1) work collectives; (2) privatization organs and local budgets, in which case settlements or remittances into the Federal Fund for Entrepreneurial Support shall be conducted in cash; and (3) the republican budget of the Russian Federation and budgets of republics within the Russian Federation, krais, oblasts, the

[illegible] autonomous okrugs, and the cities of Moscow and St. Petersburg, in which [illegible] shall be made in privatization vouchers.

If shares, packages are held in state ownership, then, for the purposes of allocating proceeds from privatization, the remaining portion of shares shall be considered to be 100 percent of the shares.

4.4 The Government of the Russian Federation shall have the right to adjust indices and regulations for the allocation of proceeds from privatization, taking into account the condition of the financial system of the Russian Federation, business conditions in the market for objects of property, and the suggestions of the relevant privatization organs.

4.5 Proceeds from privatization shall not be subject to taxation.

4.6 The activities of property management committees and of property funds of all kinds, including transactions for other sales of state and municipal property, shall not be taxed.

4.7 Proceeds from privatization shall be channelled, in accordance with established regulations, into budgets at the appropriate levels and shall be directed exclusively towards:

the maintenance of sociocultural and community objects, including those that are not part of the property aggregate of a joint-stock company and those that are, in the proceed of privatization, brought under the jurisdiction of local governing bodies;

the financing of efforts for the post-privatization support of enterprises.

4.8 In cities that are subordinate to a raion and in cities having administrative and territorial subdivisions (raions, posyoloks), proceeds from privatization may be channelled by sellers into the budget of these administrative and territorial subdivisions in order to finance the maintenance of sociocultural and community objects that have been brought under state ownership upon the privatization of an enterprise. This can be done as follows: by a petition from the administrative heads of cities and subcity raions (posyoloks) and a subsequent decision by the administrative heads of cities and raions, in the case that the issue at hand concerns the sale of municipal property, or by a decision of state administrative bodies of subjects of the Russian Federation, in the case that the issue at hand concerns the sale of state property.

4.9 Monitoring of the timeliness and correctness of the settlements of privatization organs with budgets at various levels shall be carried out by the Monitoring and Inspection Bureau of the Ministry of Finance of Russia together with the GKI of Russia.

5. METHODS OF PRIVATIZATION AND PRIVILEGES GRANTED DURING PRIVATIZATION

The actual method of privatization is determined by the working commission on privatization or the commission on privatization of the responsible committee on the administration of property in accordance with the Law of the Russian Federation "On the Privatization of State and Municipal Property of the Russian Federation," Decree of the President of the Russian Federation No. 721 of 1 July 1992 "On Organisational Measures for the Transformation of State Enterprise and Voluntary Associations of State Enterprises into Joint-Stock Societies," state and local privatisation programs, and regulatory acts not contradicting this Program.

Changes and additions to the privatization plan may be introduced by the State of Russia with mandatory reporting to the relevant financial organs and participants in the process of privatizing. However, the introduction of changes and additions to the privatization plan shall not be permitted after the publication of the announcement of the sale of an object to be privatized.

5.1 All state/municipal enterprises are divided by method of privatization into two groups:

the first group comprises small enterprises with a net value as of 1 January 1992 no greater than 1 million rubles and subject to sale by auction, bid competition, and stock auction. Work collectives of these enterprises have the right, with a qualified majority of 2/3 of the votes of all workers (at a general assembly or with a certified list of signatures), to choose the method of sale: by auction or by stock auction with unlimited participation. Such decisions are binding on the corresponding committees on the administration of the property;

the second group comprises all other enterprises, which may be privatized by any method, provided for in point 5.2 of the Program.

In cases of nonfulfillment of the provisions of this Program, of the Decrees of the President of the Russian Federation of 1 July 1992 N 721 and 14 October 1992 "On the Sale for Privatization Vouchers of Residential Buildings, Land and Municipal Property," and of the Resolution of the Council of Ministers and Government of the Russian Federation of 10 August 1993 N 757 "On the Realization of Additional Measures for the Protection of the Rights of the Citizens of Russia to Participation in Privatization," committees on the administration of the property (of the ministry and department) have the right to take decisions following the established procedure on the annulment of contracts previously concluded with the directors of the enterprises or, in cases where no contracts exist, on relieving them of their duties. In such cases, the transformation of the enterprise into an open joint-stock company proceeds on the initiative of the responsible committee on the administration of the property by the established procedure, with privileges extended to members of their work collectives only in the first variant (point 5.3.1) of the Program.

5.2. Use of the following methods of privatization shall be permitted in the procedure established by the Program:

sale of shares of open joint-stock companies formed in the process of privatization;

sale by auction of enterprises that are not joint-stock companies;

sale of enterprises that are not joint-stock companies by commercial bid competition (including those with limited participation);

sale of blocks of shares in joint-stock companies by stock auction;

sale by auction or bid competition of property (assets) of solvent, liquidating and liquidated enterprises, and also of objects whose construction is incomplete;

buy-out of rental property; sale of enterprises to associations formed in accordance with the additional privileges provided for in point 5.16;

sale of interest (shares, stocks) in state and municipal property by auction or commercial bid competition, including those with limited participation.

5.3. SALE OF SHARES OF OPEN JOINT-STOCK COMPANIES FORMED IN THE PROCESS OF PRIVATIZATION

A. Privileges granted to members of work collectives in the transformation of state/municipal enterprises into open joint-stock companies

5.3.1. In the sale (gratuitous transfer) of shares of open joint-stock companies formed via the transformation of state and municipal enterprises (including those previously transformed into closed joint-stock companies), the work collective of the enterprise shall decide on the use of one of the variants provided for by the Program in extending privileges to members of the work collective of the privatizing enterprise. These privileges shall also be extended to:

employees for whom the given enterprise is the principal place of employment;

former employees having tenure at the privatizing enterprise of not less than ten years for men and seven years and six months for women, and who left the enterprise voluntarily (including in connection with a transfer to other employment), as a result of manpower reductions, or in the course of the reorganization of the enterprise;

persons with the right, in accordance with the law of the Russian Federation, to return to their previous employment at the enterprise, including persons called up for military service while working for the state/municipal enterprise before its transformation into a joint-stock company, with the condition that such persons return to their previous employment within three months of demobilization;

pensioners, receiving a pension at the enterprise;

persons dismissed from the enterprise in the course of manpower reductions after 1 January 1992 and registered as unemployed;

workers of the enterprise receiving a pension for a handicap resulting from a work-related injury or illness;

family members who are heirs of workers of the enterprise killed at the enterprise.

All persons receiving these privileges shall be included in the calculation of the number of personnel on an equal basis with employees for whom the enterprise is the principal place of employment.

Variant 1

All members of the work collective of the privatizing enterprise and persons equivalent to them and having the right to privileges:

shall simultaneously receive gratis registered preferred (nonvoting) shares, constituting 25 per cent of the charter capital, but not more than 20 times the legislatively established minimum remuneration for one employee;

common shares, constituting up to 10 per cent of the charter capital, but not more than six times the legislatively established minimum remuneration for one employee, shall be sold by closed subscription to the members of the work collective with a discount of 30 per cent of their nominal price and payment by installment of up to three months; the initial payment shall not be less than 50 per cent of the nominal price of the shares.

The administration of the privatizing enterprise - the Director, his Deputy, Chief Engineer, Chief Accountant, Directors of separate structural divisions or subsidiaries - shall be given, under the terms of the contracts concluded with them, the right to acquire common shares at the nominal price to a total value, constituting up to five per cent of the charter capital, but not more than 2000 times the minimum remuneration established by the Laws of the Russian Federation for one person.

For enterprises with an average manpower of more than 10 thousand persons, with separate structural divisions, and also in cases where the privatization plan provides for the reorganization of the enterprise with the formation of subsidiaries, the list of administrative personnel having the right to such privileges may be broadened by a decision of the work collective.

Variant 2

All members of the work collective and persons equivalent to them and having the right to privileges shall have the right to obtain common (voting) shares, constituting up to 51 per cent of the charter capital.

In this case:

gratuitous transfer and sale of shares under privileged conditions shall not take place;

the sale price of shares shall be set in accordance with the Regulation on closed subscription, approved by GKI of Russia.

Variant 3

If a group of workers of an enterprise or any physical or legal person, acknowledged as the purchaser in accordance with Article 9 of the Law of the Russian Federation " On the Privatisation of State and Municipal Enterprises of the Russian Federation", takes on the responsibility for the fulfillment of the privatization plan of the enterprise, for ensuring the solvency of the enterprise, and receives the consent of a general assembly of the work collective to the conclusion of the appropriate agreement, the length of which shall not exceed one year (and not be subject to extension),the members of such a group shall have the right, before the expiry of the indicated period and on the fulfillment of the conditions of the above-mentioned agreement, to acquire 30 per cent of the charter capital in the form of common shares of the enterprises at their nominal price.

The procedure of concluding an agreement with a group of workers on the acquisition of shares shall be in accordance with the Regulation approved by GKI of Russia.

For the period of the agreement, the voting rights of all voting shares of the corresponding property fund shall be transferred to the indicated group.

The conditions of the agreement shall be included in the privatization plan; the conclusion of this agreement with the indicated group by the founder of the joint-stock company shall be mandatory.In the agreement shall be specified the obligations of the members of the group and the limits of their material responsibility,in the form of their private property (provided as a deposit), to the sum of not less than 200 times the minimum remuneration established by the Laws of the Russian Federation for one person at the time of the deposition of the property for each member of the group.

In this variant, all workers of the enterprise (including the members of the group) shall be sold common shares to a sum constituting 20 per cent of the charter capital, but not exceeding 20 times the minimum remuneration established by the Laws of the Russian Federation for one worker, with a discount of 30 per cent of their nominal price and a three-month period of installment payment; the initial payment shall not be less than 25 per cent of the nominal price.

In the case of nonfulfillment of the provisions of the agreement by the group, the shares to be sold to the group shall instead be sold to the public at specialized voucher auction (after 1 July 1994 at auction for money).

The procedure of distribution of shares transferred gratis (under Variant 1) shall be determined by a decision of a general assembly (conference) of the work collective by a simple majority of votes.

The sale of shares to members of the work collective and to persons equivalent to them in privileges, as set out by this Program, shall proceed by closed subscription in accordance with the regulation approved by GKI of Russia.

Committees on the administration of property shall be permitted to extend to three months the period of closed subscription of shares among workers of the enterprise, based on the specifics of the production activity of the enterprise in question.at the same time, the

sale of shares transferred to property funds may be conducted until the end of the period of closed subscription.

The decision as to the choice of variant of privileges established by this Program shall be taken by a general assembly of the work collective or shall be ascertained by a signed list of its members. A decision must receive the votes (signatures) of not less than two thirds of the listed personnel of the enterprise. In the absence of such a decision, privileges shall be assigned in accordance with the first variant.

Workers of enterprises that make up a single technological complex with the privatizing enterprise shall be offered, in accordance with a decision of the work collective and independent of the variant chosen, the right to take part in the closed subscription to shares conducted among the workers of the privatizing enterprise, under equal conditions.

5.3.2. Any shares acquired or received gratis by physical or legal persons may be sold by their owners without limitation. The establishment of limitations shall be forbidden.

5.3.3. The initial price of state/municipal enterprises in their sale at auction, by commercial (noncommercial) competition or stock auction shall be established in accordance with the Provisional Methodological Instructions on the Evaluation of the Value of Objects of Privatization approved by the Decree of the President of the Russian Federation of 29 January 1992 N 66 "On the Acceleration of Privatization of State and Municipal Enterprises," with account taken of the changes introduced by the Directive of GKI of Russia of 13 November 1993 N 763 "On Several Questions on the Application of the Provisional Methodological Instructions on the Evaluation of the Value of Objects of Privatization."

The value of property shall be evaluated on the basis of the financial balance for the accounting quarter preceding the evaluation.The value of the fixed assets of unfinished construction and equipment not yet installed shall be determined during the evaluation with no account taken of the results of the reevaluation of fixed assets conducted in accordance with the Resolution of the Government of the Russian Federation of 14 August 1992 No. 595 "On the Reevaluation of Fixed Assets in the Russian Federation," and also subsequent reevaluations of fixed assets.

The actual profits earned by enterprises in 1993-1994 shall not be used as the source of a privatization fund for the workers of the enterprise and shall not be excluded from the value of the property for the determination of the initial price of the enterprise.

5.3.4. The amount of the charter capital in the transformation of state/municipal enterprises into open joint-stock companies shall be determined by the financial balance of 1 July 1992 with no account taken of the results of the reevaluation of fixed assets conducted in accordance with the resolution of the Government of the Russian Federation of 14 August 1992 "On the Reevaluation of Fixed Assets in the Russian Federation" and subsequent reevaluations of fixed assets and currency holdings.

In this case, for the determination of the variant of privileges offered to members of the work collective, the following shall be used:

the minimum remuneration for labor as of 1 June 1992 (900 rubles);

the average manpower of the enterprise according to the data for the first six months of 1992.

All changes in the makeup and value of the property of the enterprise after 1 June 1992 shall apply to the makeup and value of the property owned by the joint-stock company. The actual profit earned by the enterprise in 1993-1994 shall not be used as a source for a privatization fund for the workers of the enterprise and shall not be excluded from the value of the property in the determination of the charter capital.

5.3.5. The size of the charter capital of joint-stock companies formed via the transformation of state/municipal enterprises formed (founded) after 1 July 1992 shall be determined by the financial balance in the accounting quarter preceding the evaluation.

In determining the size of the charter capital, the value of fixed assets, unfinished construction, and uninstalled equipment shall be determined in the evaluation with no account taken of the results of the reevaluation conducted in accordance with resolution of the Government of the Russian Federation of 14 August 1992 "On the Reevaluation of Fixed Assets in the Russian Federation," and subsequent reevaluations of fixed assets.

In this case, for the determination of the variant of privileges offered to members of work collectives,the following shall be used:

the minimum remuneration for labor in effect at the time of formation (foundation) of the state/municipal enterprise;

the average manpower of the enterprise according to the data of the six months prior to the evaluation.

5.3.6. In order to safeguard the rights of shareholders, increase in the charter capital of the joint-stock company shall be forbidden until 90 per cent of the shares of the privatizing enterprise have been sold.

B. Privileges for members of work collectives and administrations of privatized enterprises, provided after the completion of the sale of stocks for privatization vouchers

5.3.7. In the case of sale of more than 80 per cent of stocks of a joint-stock company and sale of a quantity of shares established by legislation for privatization vouchers, the right is provided:

for members of work collectives of privatized enterprises to begin to buy out (and partly to receive free) shares from the enterprise employees shareholding fund, if this fund was included in the privatization plan confirmed before the release of the Program;

for joint-stock companies in the process of privatisation to buy out a tract of land under enterprises being privatized in accordance with current legislation. Moreover, the appropriate property funds shall be the vendors of the tracts of land. The distribution of funds received from land tracts is carried out according to the standards laid set out in appendix no.1 to the Program.

C. Privileges for members of work collectives and administrations in the case where a controlling interest in state/municipal ownership is held

5.3.8. In the case where a controlling interest in state/municipal ownership is held, the privileges for the workers of enterprises are provided in the following order:

if a controlling interest constitutes 51 per cent of shares, then registered preferred shares shall pass once and without charge to all members of the work collective and those equivalent to it. These shares constitute 25 per cent of the charter capital, but not more than 20 times the minimum wage of one employee as established by the legislation of the Russian Federation. Further than this, privileges are not provided;

if a controlling interest constitutes 38 per cent of shares, then privileges for members of work collectives and those equivalent to it are provided in accordance with the first benefits option (point 5.3.1. of the Program).

In both cases, the enterprise employees shareholding fund shall not be established, all remaining nonallocated shares are subject to sale at specialized voucher auctions (after 1 July 1994, at secondary auctions).

If in state ownership 25.5 per cent is secured, then privileges for members of work

collectives and those equivalent to it are provided under the first benefits option.

D. Receipt (sale) of shares from the enterprise employees shareholding fund

5.3.9. For enterprises, requests for privatization submitted after 1st February 1994, the establishing of enterprise employees shareholding funds (hereinafter EESF) is not provided for.

Receipt (sale) of shares from the EESF is conducted in the manner established by the government of the Russian Federation and this Program.

During the transformation of state and municipal enterprises into open joint-stock companies upon the proposal by labor collectives, the enterprise employees shareholding fund can be formed by means of an investment of the appropriate property fund. The size of this investment shall not exceed 10 per cent of the charter capital of the enterprise in the case of the selection of benefits package options 1 and 3, and 5 per cent in the case of the selection of option 2 of the benefits package for members of labor collectives.

Transfer of shares from the EESF is conducted in the case where not less than 80 per cent of shares are sold and after the sale of the quantity of shares established by legislation has been completed.

Furthermore, from the total quantity of shares, a portion of the shares, which constitutes one tenth of the total number of shares sold for privatization vouchers of this joint-stock company (with the exception of shares sold or transferred to a work collective for preferential conditions), shall be subject to gratuitous transfer to members of the work collective.

The EESF shall be formed in a time period of not less than two years from the moment of registration of the joint-stock company. Members of the work collective, for whom this joint-stock company is the basic workplace, shall have the right to acquire shares from the EESF.

5.4 THE SALE OF SHARES OF A JOINT-STOCK COMPANY IN SPECIALIZED CHECK AUCTIONS

5.4.1 Before 1 July 1994, the basic form of selling shares shall be the sale of shares at specialized voucher auctions, the conduct of which is defined by the GKI of Russia, and also at interregional specialized voucher auctions and interregional all-Russian specialized voucher auctions, to be carried out in accordance with the resolution of the Council of Ministers of the Government of the Russian Federation No. 786 of 10 August 1993 "On the Sale of Shares at Interregional Specialized Voucher Auctions".

The conditions for the conduct of interregional and interregional all-Russian specialized voucher auctions shall be regulated by the GKI of Russia.

All owners of privatization vouchers, recognized as buyers in accordance with the legislation of the Russian Federation, shall be permitted to participate in specialized voucher auctions.

5.4.2. The specialized voucher auction shall be the method of selling shares at auction, under which:

all auction winners shall receive shares at the same price; participation in the auction shall be defined by means of submitting one of the two types of requests with indication either of only the quantity of privatization vouchers (request type 1) or of the quantity of privatization vouchers for buying shares with indication of the minimum quantity of shares of nominal value for one privatization voucher (request type 2);

persons submitting request type 1 shall always be among the auction winners.

The appropriate property fund, property management committee and stock-issuing enterprise shall carry out the sale of shares at specialized voucher auctions in accordance with Decree of the President of the Russian Federation No. 1229 of 14 October 1992 "On the Development of the System of Privatization Vouchers in the Russian Federation".

The use of procedures for the conduct of specialized voucher auctions other than those established by the regulation of the GKI of Russia No. 701 of 4 November 1992.

The sale of the shares of enterprises under privatization at specialized voucher auctions shall be carried out in accordance with the privatization plans, ratified by property management committees, and with the work plans for the conduct of specialized voucher auctions, which shall be mandatory for property funds.

Furthermore, the sale of shares at specialized voucher auctions shall be permitted until the closed subscription to shares among the members of the work collective has been completed.

5.4.3. Interregional specialized voucher auctions shall be auctions to be carried out in the manner established by the Resolution on specialized voucher auctions, ratified by the regulation of the GKI of Russia No. 701 of 4 November 1992. Furthermore, the collection of requests for participation in interregional specialized voucher auctions must be simultaneously organized in the territory of at least five subjects of the Russian Federation.

5.4.4. Interregional all-Russian specialized voucher auctions shall be auctions to be carried out in the manner established by the Resolution on specialized voucher auctions, ratified by regulation of the GKI of Russia No. 701 of 4 November 1992. The collection of requests for participation in such an auction shall be simultaneously organized in the territory of at least 25 regions of the Russian Federation.

Upon the conducting of an interregional all-Russian specialized voucher auction, the organization of the collection of requests in Moscow shall be mandatory.

5.4.5. Property Funds shall ensure the sale of at least 29 percent of the shares of the joint-stock company exclusively at specialized voucher auctions, in accordance with the privatization plan (with the exception of joint-stock companies established from fuel and energy enterprises that are being privatized in accordance with Decrees of the President of the Russian Federation No. 923 of 15 August 1992, Nos. 1333 and 1334 of 5 November 1992, No. 1403 of 17 November 1992, and No. 1702 of 30 December 1992), within two months of the moment of transformation.

The shares of joint-stock companies being established in the privatization process and which were formerly state-owned, having on 1 January 1992 a net value of fixed assets of more than 250 million rubles, shall be subject to sale exclusively at interregional and interregional all-Russian specialised voucher auctions, to be carried out by property funds in accordance with the Resolution on the conduct of interregional all-Russian specialised voucher auctions, ratified by regulation of the GKI of Russia No. 1853 of 28 October 1993, and in accordance with the work plan ratified by the GKI of Russia.

5.4.6 In the case where shares of a joint-stock company are used as payment for charter capital of a different joint-stock company (holding company), the quantity equivalent to the nominal value of the shares of the latter must be sold at a specialized voucher auctions and indicated in the privatization plan of the former joint-stock company. The sale of shares must also be carried out in the region where the joint-stock company, the shares of which were invested in the holding company, is located.

After 1 July 1994 shares shall be sold at auctions for money in accordance with the

resolution of the GKI of Russia.

5.5 THE SALE AT AUCTIONS OF ENTERPRISES THAT ARE NOT JOINT-STOCK COMPANIES

Auction sale is the acquisition into private ownership by physical or legal persons at open tenders auctions of objects of privatization in cases where buyers do not need to fulfil any conditions relating to the object of privatization.

Furthermore, the right of ownership shall be transferred to the buyer offering the highest price at the auction.

In the case where workers of an enterprise under privatization and persons dismissed from this enterprise due to staff reduction after 1 January 1992 and registered as unemployed are deprived of ownership rights as a result of the auction, they shall receive 30 percent of the receipts, but not exceeding 40 times the minimum wage for one worker as established the legislation of the Russian Federation.

5.6 THE SALE OF ENTERPRISES THAT ARE NOT JOINT-STOCK COMPANIES BY COMMERCIAL TENDER (WITH RESTRICTED PARTICIPATION)

5.6.1 Sale by commercial tender is the acquisition into private ownership by physical or legal persons of objects of privatization in cases where buyers need to fulfill particular conditions relating to objects of privatization. The list of conditions of tender is determined in accordance with the Resolution of the Privatization of State and Municipal Enterprises in the Russian Federation by tender. Conditions not provided for in the above Resolution are acceptable.

The mandatory conditions for the sale of all objects of commerce of the food-service industry and of basic services are to preserve the line of operation and to prohibit cessation of the work of the privatized object for more than two months after the conclusion of the deal and/or cumulatively 3 months in the course of the calendar year. Reducing the work schedule of the privatized object is only permitted by agreement with local administration.

In the case where workers of an enterprise under privatization, and persons dismissed from this enterprise due to staff reduction after 1 January 1992 and registered as unemployed are deprived of ownership rights as a result of the tender, then they shall receive compensation amounting to 20 percent of the receipts, but not exceeding 30 times the minimum wage for one worker as established by the legislation of the Russian Federation.

5.6.2 Commercial tender shall be conducted in the form of open or closed tenders. Furthermore, in commercial tender the right of acquisition shall belong to the buyer offering the highest price.

Sale at commercial tender with restricted participation is permitted (in accordance with local privatization programs) only during privatization of enterprises of commerce, of the food-service industry and of basic services situated in rural areas, urban posyoloks, raions of the Far North and similar areas.

Only workers of the enterprise under privatization and inhabitants of the region are permitted to participate in the tender.

5.7. THE SALE OF THE SHARE PACKAGES OF JOINT-STOCK COMPANIES BY INVESTMENT TENDER

When buyers are required to make investments, share packages of state-owned joint-stock companies shall be sold by investment tender.

The criterion for selecting tender winners shall be the total size of the investment, discounted to its maturity and taking account of the rates of the Central Bank of the Russian Federation at the moment of carrying out the tender.

The obligatory requirements for the conduct of the tender are:

that, in the month following the completion of the investment tender, the tender winner shall deposit at least 20 percent of the total volume of the investment into the settlement account of the enterprise (0.5 percent of this amount shall be transferred by the investment tender winner in equal portions to the accounts of the appropriate property management committee and the appropriate property fund) and furthermore,in individual cases, the size of the initial payment may be reduced to 10 percent by a decision of the government of the Russian Federation;

that the investment shall be finalized in not more than three years;

that payment for a share package being sold at an investment tender shall be made at its nominal value.

All investment tenders shall be open, i.e. any interested physical or legal persons may participate in them.

Investment tenders shall be conducted in accordance with the Resolution ratified by the GKI of Russia.

The debt of an enterprise, whose shares are sold at an investment tender, shall be paid off by the winner of the investment tender as a part of the investment.

5.8. Upon the sale of state and municipal enterprises (and also the property of liquidated enterprises) by tender or at auction to a partnership (joint-stock company) including at least one third of the listed workers of an enterprise (subdivision) under privatization, a discount of 30 percent from the selling price shall be granted as well as an extension of the payment deadline of up to three months. Furthermore, the amount of the initial payment defined by the privatization plan, or, in the absence of the necessary deed, by the vendor, may be less than 25 percent of the selling price and may be submitted by the buyer in the following form: up to 80 percent in privatization vouchers, and the remainder in money.

5.9. Physical and legal persons who are owners of state and municipal enterprises at auction (tender) shall be granted the right to conclude long-term lease agreements on nonresidential state/municipal premises, buildings and structures which are being used by these enterprises but are not part of the property acquired by them. In this case, the appropriate property management committee shall be the vendor. Such a buy out shall be conducted according to the price established on the basis of a system to be approved by the GKI of Russia.

Owners of privatized state/municipal enterprises shall have the exclusive right to acquire tracts of land being used by these enterprises.

Alteration of the conditions of lease agreements on the above-mentioned premises, buildings and structures, in comparison with those earlier concluded, shall only be permitted upon agreement of the parties, unless otherwise provided for in the conditions of the agreement.

5.10. In cases, during the conducting of an auction (tender) for the sale of enterprises under privatization, where the physical or legal person recognized as the buyer in accordance with article 9 of the Law of the Russian Federation "On the Privatization of State and Municipal Enterprises of the Russian Federation" is the only participant in the auction (tender), then the enterprise shall be sold to this person for 10 times the value if it is situated in rural areas and in labor posyoloks, and for 100 times the value if situated in a city, the value being defined in accordance with its appraisal certificate.

Privileges shall not be granted to workers of an enterprise who have become its buyers or to partnerships (joint-stock companies) in the case provided for in 5.8.

5.11. Upon the sale of an enterprise in the process of privatization by tender or at auction, the amount of the down-payment (deposit) collected from the participants shall be set at 100 percent of the initial price of the object, but it shall not exceed 1000 times the minimum wage as established by the legislation of the Russian Federation.

5.12. THE SALE OF THE PROPERTY (ASSETS) OF ENTERPRISES WHICH ARE EITHER CURRENTLY OPERATING, UNDER LIQUIDATION OR WHICH HAVE ALREADY BEEN LIQUIDATED, BY TENDER, AT AUCTION, OR AT INVESTMENT TENDERS. THE SALE OF INCOMPLETELY CONSTRUCTED OBJECTS BY TENDER, AT AUCTION, OR AT INVESTMENT TENDERS

5.12.1. The sale of property (assets) of enterprises under liquidation or which have already been liquidated shall be conducted exclusively at auction by the appropriate property funds (property management committees) in accordance with the resolution to be ratified by the GKI of Russia.

In this case, workers of the enterprise, and persons dismissed from this enterprise due to staff reduction after 1 January 1992 and registered as unemployed, shall be paid a sum amounting to 50 percent of the remaining monetary receipts of the property (assets) after the requirements of the creditors have been met, but not more than 40 times the minimum monthly wage for one worker as established by the legislation of the Russian Federation.

5.12.2. The sale of the property (assets) of currently operating state/municipal enterprises shall be carried out exclusively for money with authorization of the appropriate property management committee at an auction organised by a property fund, in the manner established by the GKI of Russia.

Furthermore, 80 percent of the proceeds received from the sale of property shall be left at the disposal of the enterprise and may not be used to pay wages, and 20 percent shall be allocated in accordance with the standard allocation of proceeds from privatization, as established in Appendix 1 to the Program.

The outcomes of the auction shall be drawn up in the form of a purchase and sale contract.

5.12.3. Privatization of assets of incompletely constructed objects shall be conducted exclusively for money taking into account the opinions of the ministries and departments:

by means of the sale of the assets of these objects at auction or by tender;

by means of the establishment of an open joint-stock company with 100 percent state capital with the subsequent sale of stock.

The distribution of monetary proceeds from the sale of assets of incompletely constructed objects shall be conducted in the following manner:

50 percent to the enterprise from whose property aggregates the assets of incompletely constructed objects were extracted;

the remaining monetary proceeds shall be distributed equally between the appropriate property management committee and property fund, and shall be directed to the financing of the privatization process.

The decision on the selection of one of the above-mentioned methods for the privatization of incompletely constructed objects shall be taken by the appropriate property management committee. Labor commissions for the privatization of state/municipal enterprises shall have the right to decide on the exclusion of incompletely constructed objects

ownership with the purchaser or until more than 75 percent of the stock in the enterprise being privatized has been sold, in order to protect the interests of the employees of enterprises being privatized, the following actions are prohibited without the assent of the appropriate property management committee and without taking into account the opinion of the appropriate sectorial ministry and department:

reorganization, liquidation, or a change in the structure of the enterprise; amending or terminating the validity of previously concluded lease agreements on nonresidential premises, buildings, structures occupied by enterprises being privatized, or amending or terminating the validity of lease agreements for property leased to prospectors' artels;

changing the manpower plan of the enterprise, reducing the size of the workforce without a decision by the labor collective of the enterprise (subdivision) or organs empowered by them, to terminate or transfer to other duties workers and management personnel of the enterprise (subdivision) who are members of privatization labor commissions, except in cases of voluntary resignation.

5.15.2 During the transformation of enterprises to open joint-stock companies, in accordance with Decree of the President of the Russian Federation No 721 dated 1 July 1992 the date of adoption of a decision by a labor collective to privatize shall be the date of release of the order by the chief executive officer of the enterprise or the date of the decision by the general meeting of the labor collective to form a working commission on the privatization of that enterprise.

5.15.3 From the moment of the adoption of a decision by the labor collective to apply for privatization, and until the sale of more than 75 percent of the stock in the enterprise being privatized, the sale of property, including real estate, and the transfer of it from the assets of the enterprise being privatized without the assent of the appropriate property management committee is prohibited.

The employees of an enterprise being privatized - shareholders - shall be exempted from the payment of tax on the sale of stock belonging to them.

5.16. ADDITIONAL BENEFITS IN THE PRIVATIZATION OF STATE/MUNICIPAL ENTERPRISES

The following additional benefits shall be established in the privatization of state/municipal enterprises:

partnerships, consisting only of employees of enterprises whose workforce is made up of more than 50 percent handicapped persons at the time of the adoption of a decision by the labor collective to apply for privatization and if the partnership contains no less than half of the total number of handicapped employees, in accordance with a resolution approved by the GKI of Russia, shall have the priority right to acquire such enterprise at its residual value with up to 80 percent of payment made in privatization vouchers (for the period until 1 July 1994);

if the number of handicapped employees is less than 50 percent but greater than ten percent of the total number of employees, then the conditions for the sale of the enterprise must include a requirement by the buyer to preserve the number of job positions determined by the privatization plan for the handicapped and to provide them with special working conditions;

partnerships consisting of not less than two-thirds of the total number of employees of a state/municipal arts and crafts enterprise shall have a priority right to acquisition of the enterprise at its residual value with up to 80 percent of payment made in privatization

vouchers (for the period until 1 July 1994);

regardless of the benefits package option chosen by the labor collective in the transformation of arts and crafts enterprises into open joint-stock companies, the leading artists and craftsmen shall be afforded the right to acquisition of stock at nominal value in an amount of five percent of the charter capital greater than that provided for in the labor collective benefits, with payment for this additional acquisition made exclusively in privatization vouchers;

in the privatization of enterprises located in settlements with a population of less than 10,000 people, as well as in closed administrative and territorial units, with the assent of the labor collective, all the inhabitants may participate in a closed subscription for stock in the enterprise being privatized which is subject to sale to that labor collective, this provided that the number of employees of the enterprise being privatized comprises more than half of the employable population of such settlement;

in the privatization of rural basic services enterprises, the labor collective shall enjoy privileged right to acquisition of the enterprise, provided that the participants observe the conditions set forth for tenders.

5.17 In calculating the benefits to members of labor collectives in the process of privatization by means of transformation of a state/municipal enterprise into an open joint-stock company on the basis of minimum wage, that minimum wage shall be defined as that which was fixed by legislation as of 1 July 1992, and in privatization by other means, at the moment of the adoption of the Program, unless otherwise established by privatization legislation. The determination of down payments or fines shall be based on the minimum wage on the date of their remittance.

5.18. REORGANIZATION AND DEMONOPOLIZATION OF ENTERPRISES DURING THEIR PRIVATIZATION

5.18.1. The creation of joint-stock companies (including holding companies) on the basis of concerns, unions, associations and other amalgamations of enterprises, who have among their participants state and/or municipal enterprises shall be prohibited, with the exception of cases where their organizational-legal form is brought into compliance with articles 9-12 of the Law of the Russian Federation "On Enterprises and Entrepreneurial Activity.'"

5.18.2 The creation of holding companies in the transformation of state and municipal enterprises into joint-stock companies shall be conducted in accordance with the temporary regulation on holding companies formed during the transformation of state enterprises into joint-stock companies approved by Decree of the President of the Russian Federation No 1392 dated 16 November 1992 "On the Methods for Fulfilling Industrial Policy in the Privatization of State Enterprises".

No more than ten percent of the stock of any joint-stock company formed in the process of privatization of a state/municipal enterprise may be invested into the charter capital of a joint-stock company formed with state participation (including holding companies).

Holding companies may be created only with the prior assent of the appropriate authorities and administrations of subjects of the Russian Federation, on whose territory the enterprises comprising the holding company are located.

5.18.3 The creation of enterprises, as well as the contribution of property investments into the charter capital of enterprises (of any organizational-legal form) by

amalgamations of state/municipal enterprises whose organizational-legal form has not been brought into compliance with articles 9-12 of the Law of the Russian Federation "On Enterprises and Entrepreneurial Activity" shall not be permitted.
The legal successors to the abovementioned amalgamations as founders and participants (shareholders, stockholders) shall be the enterprises/participants in the abovementioned amalgamations (if there is documented evidence that the latter's investments were composed of purpose-oriented and other contributions by these enterprises), or the appropriate property management committee (in all other cases).

5.18.4 The creation of or investment into the charter capital of enterprises (of any organizational-legal form) by any state administrative bodies, organs of local self-government, or state or municipal institutions, with the exception of property management committees and property funds, shall not be permitted.

5.18.5 The privatization of state and municipal enterprises by means of sales of stock shall be after their transformation exclusively into open joint-stock companies. Enterprises of other organizational-legal forms, previously created during the transformation of state/municipal enterprises, shall be subject to transformation into open joint-stock companies during privatization.

The rights of the state as a participant (shareholder, stockholder) in these enterprises shall be exercised by the appropriate property management committees and property funds.

The latter shall be required to provide for the transformation of these enterprises, and to conduct the privatization of any state or municipally-held interest in these enterprises in accordance with current privatization legislation.

5.18.6 Upon the acquisition of property, interest (shares), or stock in enterprises being privatized (joint-stock companies, partnerships) for money:

legal persons (residents and nonresidents) shall present, in cases of transactions for sums greater than 500,000 times the minimum wage established by legislation, evidence (an official document) of the source of the funds and their legality in accordance with the procedure approved jointly by the Federal Counterintelligence Service of the Russian Federation, the GKI of Russia;

individuals shall present, in cases of transactions for sums greater than 5000 times the minimum wage established by legislation, an income statement in accordance with the procedure approved jointly by the Federal Counterintelligence Service of the Russian Federation, the GKI of Russia and the State Tax Service of the Russian Federation.

5.18.7 Decisions on the segregation of organizational subdivisions from the aggregate of enterprises in the process of their privatization shall be adopted by the appropriate property management committees in accordance with antimonopoly organs and sectoral ministries and departments, on the basis of the decisions of the labor collectives of the enterprises (organizational subdivisions). Decisions on the segregation of organizational subdivisions from amalgamations of enterprises, in the process of bringing their organizational-legal form into compliance with current legislation shall be adopted on the basis of the decisions of the labor collectives of the enterprises, taking into account the opinions of antimonopoly organs and sectoral ministries and departments (except for enterprises in foreign trade amalgamations).

The decision to segregate an organizational subdivision must not violate the integrity of a manufacturing complex.

5.18.8 Monopolist enterprises are subject to reorganization during or after

privatization in accordance with current legislation.

In the privatization of enterprises recognized in the established manner as dominating the Russian (federal) market, the GKI of Russia, and property management funds who are empowered with the rights of agency of the GKI, are within their rights as representatives of the State Committee of the Russian Federation for Antimonopoly Policy and the Support of New Economic Structures or its territorial administrations (hereinafter - antimonopoly organs) to adopt a decision:

to include in the charter of the joint-stock company being created requirements for the mandatory prior approval by antimonopoly organs of any acquisition by such company of stock, shares, or interest in the charter capital of any other institution selling on the market similar or identical goods (or services);

to include in the privatization plan requirements for the mandatory prior conclusion of an agreement (contract) with antimonopoly organs which would set forth the requirements for the enterprise in deterrence of monopolistic activity and unethical competition, and responsibility for failure to abide by such agreement.

5.19 THE DISPOSAL OF STATE-OWNED OBJECTS LOCATED ABROAD

5.19.1 Privatization and disposal of state property located abroad shall be conducted in the manner set forth by the laws of the Russian Federation, decrees of the President of the Russian Federation, or resolutions of the Government of the Russian Federation.

5.19.2 The privatization (sale) of state-owned objects of the Russian Federation, located within the territory of independent states - the former republics of the USSR, shall be conducted after the settling of issues of ownership rights on the basis of intergovernment and interstate treaties.

6. SECTORAL SPECIFICS OF THE PRIVATIZATION OF STATE/MUNICIPAL ENTERPRISES

6.1 The privatization and transformation into joint-stock companies of state enterprises and of industrial and scientific-industrial associations in the fields of electrical power, nuclear power, gas, coal, oil, oil refining and petroleum products, the defense complex, mining and processing of precious metals and stones, objects of social-cultural and community importance to the enterprises being privatized, railway transportation, objects of the Russian joint-stock company "Rossiiskii Nikel'", shall be regulated by the current decrees and orders of the President of the Russian Federation.

6.2 The creation of new all-Russian integrated monopolies (holding companies and enterprises which administer the shares of the joint-stock companies being created) is permitted exclusively in the fuel, power, and nuclear complex, and only in cases provided for by decree of the President of the Russian Federation, with the assent of the state governing and administrative bodies of subjects of the Russian Federation, and of the State Committee for Antitrust Policies and the Support of the New Economic Structures of the Russian Federation.

6.3 Within six months after the adoption of this privatization Program, for the purpose of the creation of a competitive market and for the protection of consumer interests, the Government of the Russian Federation shall provide for the creation of independent oil stock companies, which will provide for the extraction of oil, oil refining, and also the sale of

oil and petroleum products, by means of the consolidation of shareholdings under the administration of the state enterprise "Rosneft', with their subsequent sale on the secondary market.

Members of paramilitary units of the Ministry of Fuel and Energy of the Russian Federation (responsible for gas and oil disaster response and gusher containment), of paramilitary mining rescue units belonging to metallurgical mining enterprises and the gold and diamond industries, who provide mining safety, shall be granted special privileges to the acquisition of stock in the enterprises which they service within the framework of general benefits which are granted to members of the worker's collective of those enterprises.

6.4 The privatization of enterprises involved in the primary processing of agricultural products, fish, seafood products and of enterprises providing maintenance and logistics to the agroindustrial complex shall be conducted in accordance with the Decree of the President of the Russian Federation dated October 27, 1993, No. 1767, "On the Regulation of Land Relationships and the Development of Agrarian Reforms in Russia," and with this Program. Furthermore, the issuing of stock in these enterprises shall be conducted regardless of the number of workers and value of its fixed assets, with benefits to members of the worker's collective being offered under options one and three.

All the remaining stock shall be offered, within three months after the adoption of a decision on privatization, at closed voucher auctions to agricultural and fish product producers, suppliers or consumers of services, recognized as purchasers in accordance with article 9 of the Law of the Russian Federation "On the privatization of state and municipal enterprises in the Russian Federation", and also to the rural population of the production zone of these enterprises in accordance with the regulation approved by the GKI of Russia on specialized closed voucher auctions.

Nonassigned shares of enterprises in the agroindustrial complex shall be sold at specialized voucher auctions without restrictions on the composition of the participants. A decision on the issuance of "Golden Shares" (Zolotye Aktsii) shall be adopted upon the transformation of tobacco manufacturing enterprises into open joint-stock companies.

6.5 The privatization and selling of released military property (except armaments and ammunition) shall be conducted by the Ministry of Defense of the Russian Federation in the manners established by the decrees of the President of the Russian Federation dated November 30, 1992, No. 1518, "On the procedure of reorganizing and utilization of released military property," and December 28, 1992, No. 1659, "On measures for the social welfare of military personnel, veterans their family members".

6.6 The privatization of publishers, printing houses and wholesale book trading enterprises of the Press Committee of the Russian Federation shall be conducted in accordance with regulations approved by the Government of the Russian Federation. "Golden Shares" (Zolotye Aktsii) shall be issued for a period of three years upon the transformation of wholesale book trading enterprises into open joint-stock companies. The right to participate in a closed subscription for stock shall be granted, upon the transformation of publishing houses into open joint-stock companies, to workers of the editorial staff of newspapers and magazines, who were earlier a part of the staff of these publishing houses, including writers and editors on the editorial staff of newspapers and magazines.

6.7 The privatization of objects of the scientific-technical field shall be conducted in accordance with the regulation approved by the Government of the Russian Federation.

6.8 The privatization of objects and enterprises related to the field of Communications (except objects and enterprises of the retail network "Rospechat'") shall be carried out in accordance with the resolutions of the Government of the Russian Federation.

6.9 The privatization of objects and enterprises of a sanatorium-resort nature which are federally owned shall be conducted in accordance with resolutions of the Government of the Russian Federation.

Upon the transformation of enterprises of wholesale trade, objects and enterprises of a sanatorium-resort nature, which are federally owned, into open joint-stock companies, benefits to members of the worker's collective shall be granted only benefits option 1 of the established in this Program.

6.10 The privatization of objects of amateur and professional sports shall be carried out in accordance with resolutions of the Government of the Russian Federation.

6.11 Upon the privatization of timber farms by means of the sale of stock in open joint-stock companies, and in the event of the segregation from such farms of organizational subdivisions engaged in milling activities, all workers of the former amalgamated forestry enterprise shall be allowed to participate in a closed stock subscription. In the case of sale at voucher auctions of stock in wholesale trade and food service industry enterprises which serve the enterprises and organizations of the Russian Federal Forestry Service, only inhabitants of lumbering settlements may be purchasers.

This procedure shall apply to all organizational subdivisions engaged in milling activities (the preparation of lumber from raw timber and its processing) segregated from amalgamated forestry enterprises of the Russian Federal Forestry Service.

6.12. Released motor vehicles and water transport vessels of organizations, institutions and enterprises (including those being privatized) shall be sold at auction. Furthermore, a special privatization system with a mixed form of payment shall be used: until July 1, 1994, 50 percent in voucher and 50 percent in cash, and after July 1, 1994 - only in cash, and furthermore:

30 percent of monetary proceeds shall go to the organization, institution or enterprise from whose holdings the indicated property was released;

70 percent of monetary proceeds shall be divided equally between the property management fund and the property fund. These proceeds, received by these privatization organs, shall be allocated for the financing of the process of privatization.

6.13 The privatization of federally-owned cultural objects (including objects and enterprises of cinematography) shall be carried out in accordance with regulations approved by the Government of the Russian Federation.

Upon the privatization of federally-owned cultural objects (including objects and enterprises of cinematography) by means of the sale of stock in open joint-stock companies, "Golden Shares" (Zolotye Aktsii) may be issued and held in state ownership for a period of three years; this in the interest of preventing the restructuring of the object.

6.14 If objects of social or community significance or residential real estate are not included in the charter capital of an enterprise being privatized, and if these objects or real estate are earmarked for transfer into municipal ownership, then the appropriate organs of self-government must, within six months of the day of adoption of the privatization plan, receive the objects or real estate into their assets and conclude a contract with the enterprises for the maintenance of such objects; and if necessary, must preserve contractual

relations with the privatized enterprise/former owner, which is fulfilling the obligations of the new owner in the maintenance of the residences or social and community objects.

6.15 Sales at auction are prohibited in the privatization of enterprises which produce baby food, and if they are transformed into open joint-stock companies, a decision to issue "Golden Shares" (Zolotye Aktsii) shall be adopted.

6.16 Objects of departmental commerce and of the food-service industry which serve institutions, enterprises and organizations of the Russian Federal Forestry Service shall be privatized in accordance with a special regulation approved by GKI of Russia, taking into account the proposals of the Russian Federal Forestry Service.

6.17 In the privatization of state/municipal enterprises, the new owner inherits all the rights and responsibilities for the fire safety of the enterprises.

6.18 The privatization of foreign trade associations of the Ministry of Foreign Economic Relations of the Russian Federation and other ministries and departments of the Russian Federation shall be conducted in accordance with a regulation approved by the Government of the Russian Federation, upon presentation by the GKI of Russia and the MFER of Russia.

6.19 The privatization of civil defense objects, except those indicated in section 2.1, shall be conducted in accordance with a regulation approved by the Government of the Russian Federation.

6.20 A decision to issue "Golden Shares" (Zolotye Aktsii) shall be adopted in the transformation into open joint-stock companies of testing factories which are part of the system of the Russian Federation Committee for Standardization, Weights and Measures, and Certification.

6.21 Enterprises of the Ministry of Education of the Russian Federation shall be transformed exclusively into open joint-stock companies, regardless of the value of their fixed assets. GKI of Russia may adopt a decision to issue "Golden Shares" (Zolotye Aktsii) in the transformation of these enterprises into joint-stock companies.

It shall be a mandatory condition in the transformation of enterprises of this ministry that two-thirds of their production output (both in type and volume) as measured at the moment remain dedicated to the production of study materials.

6.22 Enterprises and objects of the motor-vehicle and highway industries which are objects or which are assigned permanent mobilization tasks shall be privatized with consideration for the opinion of the State Committee for Emergency Situations.

6.23 All enterprises, scientific research and design organizations which are under the jurisdiction of the Russian Federation Committee of Metallurgy shall be privatized with consideration of the opinion of that committee, and only by means of sale of stock in open joint-stock companies, regardless of the size and value of their fixed assets.

6.24 The privatization of folk arts and crafts enterprises shall be conducted with mandatory preservation of their line of activity and with consideration for the opinion of the State Committee of the Russian Federation for Industrial Policy.

6.25 In the transformation of federally or municipally-owned hotel complexes, hotels, motels, pensions, campgrounds, and tourist/excursion objects into open joint-stock companies, benefits shall be provided to members of the labor collective only under benefits option 1, as set forth in this Program.

6.26 "Golden Shares" (Zolotye Aktsii) shall be issued in the transformation of the following into open joint-stock companies: objects and enterprises of the medical industry, pharmaceutical warehouses, medical equipment warehouses, as well as enterprises and objects in the scientific and technical fields of the chemical complex, which contain sites with toxic substances of hazard classes 1 and 2.

6.27 A decision on the privatization of enterprises and objects which manufacture poisonous substances and temporary exterminants shall be adopted only after the completion of destruction of those substances and the decontamination of equipment.

6.28 The privatization of passenger transport enterprises which are also involved in cargo transfer shall be conducted in accordance with the resolutions of the Government of the Russian Federation.

6.29 The transformation into open joint-stock companies and the privatization of enterprises and objects of the Russian Federal Geodesy and Cartography Service, indicated in section 2.2 of this Program, shall be conducted with mandatory preservation of their line of activity and with consideration for the opinion of the Russian Federal Geodesy and Cartography Service.

6.30 Objects and enterprises of rural commerce, of the food service industry, and of basic services with a net value of fixed assets as of 1 January 1992 of less than 0.5 million rubles are subject to sale exclusively at tenders and investment tenders.

6.31 In the privatization of geological enterprises, those organizational subdivisions and objects not subject to privatization are segregated from the body of the enterprise. Shares of geological joint-stock companies held in federal ownership may be sold prematurely on the basis of decisions of the Government of the Russian Federation.

6.32 Per resolution of the Government of the Russian Federation, in the privatization of objects and enterprises involved in the processing of precious metal ores, precious and semi-precious stones, one of the following property appraisal options shall apply, at the behest of the labor collective:

option 1 - without inclusion of precious and semi-precious stones, precious metals in the value of property to be bought out. In this case precious and semi-precious stones as well as precious metals shall remain in state ownership and shall be used by the enterprise in accordance with a contract concluded with the Committee of the Russian Federation for Precious Metals and Precious Stones;

option 2 - with inclusion of precious and semi-precious stones, precious metals in the value of property to be bought out, at the current price at the moment of the approval of the privatization plan.

6.33 In the privatization of state and municipal enterprises, the procedure for assessing ecological impact and workplace safety at sites with potential chemical, explosive, fire, and toxic hazards shall be established by the GKI of Russia with consideration for the

proposals of the Ministry of Environmental and Natural Resources Protection of the Russian Federation and the appropriate sectoral ministries and departments, and shall include the issues of: ecological survey; reflection of ecological and safety issues in the conditions for privatization plans and tenders; presentation of requirements for environmental cleanup, preferential appraisal property on nature reserves; and the creation at enterprises of environmental cleanup funds.

The abovementioned ministry and GKI of Russia shall approve the list of ecologically hazardous enterprises for consideration in the process of privatization.

The privatization of enterprises subject to an assessment of ecological requirements shall be conducted in accordance with the Regulation approved by the Government of the Russian Federation.

7. CONDITIONS FOR ISSUING PRIVATIZATION CREDITS.

Commercial banks of the Russian Federation and foreign banks may issue credit for privatization transactions in accordance with current legislation.

Credit resources may be allocated by the Central Bank of the Russian Federation only for the holding of voucher auctions.

Credit resources may be allocated for local privatization programs only from those funds at the disposal of the appropriate local authorities.

The Government of the Russian Federation, on behalf of the Russian Federation shall provide for the issue of preferred credits from international financial institutions (banks) to support the privatization process in Russia.

8. THE USE OF PRIVATIZATION VOUCHERS.

This program shall implement the system of privatization on the basis of use of privatization vouchers in accordance with the decrees of the President of the Russian Federation No. 914 dated 14 August 1992; No 1228 dated 14 October 1992; No 1229 dated 14 October 1992, No 1304 dated 26 October 1992, No 1391 dated 16 November 1992; No 1705 dated 31 December 1992; No 7 dated 10 January 1993; No 216 dated 12 February 1993; No 2004 dated 24 November 1993, within the validity period for privatization vouchers which ends 1 July 1994.

8.1. Citizens of Russia and other persons entitled to receive privatization vouchers can use privatization vouchers issued in 1992 with a nominal value of 10 thousand rubles for the acquisition of objects of privatization.

The deadline for issue of privatization vouchers shall be extended for those persons on extended voyages and on extended tours of duty.

8.2. Privatization vouchers may be used as payment by buyers of the following objects during privatization:

enterprises, their subdivisions, property, shares in Joint-stock companies and interests in the charter capital of enterprises federally or state-owned by republics within the Russian Federation, krais, oblasts, autonomous oblasts, autonomous okrugs, the cities of Moscow and Saint-Petersburg, or municipally owned;

tracts of land, in the procedure provided for in the decrees of the President of the Russian Federation No 631, dated 14 June 1992 "On the approval of a procedure for the sale of land tracts during the privatization of state and municipal enterprises, and land tracts offered to citizens and their associations for entrepreneurial activity"; and No 1228 dated 14

October 1992 "On the sale of residential property, land tracts, and municipal property for privatization vouchers."

shares in voucher investment funds;

shares in social welfare voucher investment funds;

leases and rights of purchase.

The size of payments which must be made in privatization vouchers shall be established by decrees of the President of the Russian Federation and this Program.

With consideration of the sectorial and regional particularities of privatization, the size of payments made in privatization vouchers may be changed in accordance with decrees of the President of the Russian Federation.

8.3. No other systems shall be permitted for the gratuitous transfer of state or municipal property to the ownership of citizens of the Russian Federation in republics, krais, oblasts, autonomous oblasts, autonomous okrugs, the cities of Moscow and Saint-Petersburg, in raions and cities, except for the transfer of shares from EESFs and under the first benefits option during share issue in the process of privatization, provided for in this program.

8.4. It shall be forbidden to refuse to accept privatization vouchers as a form of payment during privatization. No fees may be charged for the acceptance of privatization vouchers by property funds as a form of payment during privatization.

Brokers who conduct voucher auctions in accordance with Russian Federation privatization legislation under the auspices of property funds shall be exempt from Value Added Tax for the expenses incurred in holding voucher auctions, which are reimbursed to them by property funds.

8.5. The state shall guarantee to the owner of a privatization voucher the right to use it for the acquisition of objects of privatization, in accordance with the legislation of the Russian Federation.

8.6. Privatization vouchers may be circulated in certificate or non-certificate form.

To provide for the issue, circulation, and safekeeping of shares in privatized enterprises, and privatization vouchers in non-certificate form (as entries in accounts), as well as to accept and process the mandates of the owners of privatization vouchers and of shareholders, depositories shall be created. A regulation on these depositories shall be approved by the GKI of Russia in collaboration with the Securities and Exchange Commission of the President of the Russian Federation.

8.7. Purchase and sales of privatization vouchers and the acquisition of securities on them, including shares in voucher investment funds and shares in enterprises being privatized, shall be tax exempt. The value of a privatization voucher issued to a person who has the right to receive it under current legislation, is not included in the receiver's total taxable income, and is exempt from income taxation.

Income realized from the profitable sale of shares in voucher investment funds shall be exempt from taxation.

Voucher investment funds and investment institutions are exempt from property tax. The services of depositories and auditing firms provided by voucher investment funds and investment institutes are exempt from V.A.T.

8.8 The Government of the Russian Federation and higher organs of executive power of subjects of the Federation guarantee financial training and the publication in each region of

comprehensive information on privatization and property fund bulletins with obligatory publication of time tables for the sale of objects, including the conducting of voucher auctions, plans to privatize enterprises, lists of privatized enterprises, and also methodological and normative documents on the problems of privatization.

8.9 In order to prevent abuse, it shall be forbidden to borrow or lend privatization vouchers, to receive or give privatization vouchers as tax payments, and to carry out other operations with privatization vouchers which are not stipulated by legislation of the Russian Federation on privatization.

8.10 The financing of issue, safekeeping, redemption, and destruction of privatization vouchers shall be funded from the republican budget of the Russian Federation, and also by means for privatization which are forthcoming in the orders of the appropriate property-management committees and property funds.

All organizations, enterprises and institutions which issue certificates of deposit of privatization vouchers, collect, hold for safekeeping, redeem or destroy privatization vouchers, must keep records and present accountability on the movement of privatization vouchers in the manner established by GKI of Russia.

8.11 Up to 10 percent of the total shares of a JSC sold at a voucher auction (provided that at least 29% of the shares of the JSC were sold at voucher auction) may be sold for rubles, with the proceeds from the sale allocated to cover the expenses for holding the voucher auction. Thirty percent of the proceeds from such sale shall be allocated for financing the safekeeping and destruction of privatization vouchers, and the remaining proceeds shall be allocated to property funds to cover expenses for holding voucher auctions and for the redemption of privatization vouchers.

In this case, there is no need to amend Section II of the privatization plan.

9. DEVELOPMENT OF A SECONDARY MARKET

9.1. In order to provide a system for capital circulation (purchase and sales of shares), and in order to introduce shareholder registers and noncash transfer of privatization vouchers and shares within the country, independent registrars, depositories, and accounting organizations shall be created.

The regulation on shareholder registers shall be approved by the Russian State Property Committee, in collaboration with the President of the Russian Federation's Commission for securities and funds markets.

9.2. Property funds (or in their absence, the appropriate property administration committee) shall bear responsibility for accruing and redemption of invested vouchers. Property administration committees shall bear responsibility for the destruction of vouchers.

9.3. No type of investment fund shall have the right to exchange shares issued by itself for shares of a joint-stock company created during the process of privatization , the holder of which are property funds.

9.4. Legal persons conducting investment activity in the manner established for investment funds must bring their charter documents into conformity with that Russian Federation legislation which regulates the creation and activities of investment funds. Specialized privatization investment funds which accrue privatization vouchers from individual

citizens are within their rights to hold in their assets not more than 25 percent of the securities of one issuer; and to acquire and hold in their assets the shares of other investment funds.

The investment activities of specialized privatization investment funds which accrue privatization vouchers from individual citizens shall be exempted from the following for the first two years following their registration:

advance payments of profit taxes;

taxes on dividends paid out by enterprises on their shares, which are held by specialized privatization investment funds which accrue privatization vouchers from individual citizens;

taxes paid on the registration of securities issue prospectuses.

Specialized privatization investment funds which accrue privatization vouchers from individual citizens shall be exempt from payment of value added sales tax on the purchase of shares of an enterprise being privatized.

9.5. In the interest of regulating the development of the securities market, until the implementation by the Russian Federation of standard regulations governing the activities of investment banks:

banks may not purchase interests (shares, stock) in enterprises being privatized or in specialized privatization investment funds which accrue privatization vouchers from individual citizens, neither for money nor for privatization vouchers acquired by them; nor may they own more than 10 percent of the shares of any joint-stock company, nor may more than 5 percent of their assets consist of shares in joint-stock companies;

banks may accept from individual citizens and legal persons privatization vouchers, securities of enterprises being privatized and of investment funds for safekeeping.

9.6. Should no deadline be indicated in the privatization plan for the sale of share packages which are to be disposed by the appropriate property fund, then those packages must be sold within three months of their transfer to the fund.

9.7. Government administrative organs shall provide all possible assistance to current and future military social security voucher investment funds in disposing of vouchers owned by military personnel, civilian personnel of the Armed Forces of the Russian Federation and other military and paramilitary ministries and administrations, veterans and the family members of all the above mentioned groups.

A military social security voucher investment fund may be one in which at least 75 percent of the stockholders are individual citizens belonging to one of the above categories.

9.8. The chairman of the appropriate property fund shall bear personal responsibility for conforming with deadlines for sale of an enterprise's shares, as set forth in the privatization plan (plan - schedule for voucher auctions). In case of violation by a property fund of the deadline for sales of an enterprise's shares, (resulting in non-fulfillment of the enterprise's privatization plan), the property administration committee must commence the sale of those shares which have been turned over to the fund, within 15 days of the deadline set forth in the privatization plan.

9.9. Property administration committees are responsible for the creation in each region of the necessary network of independent registrars and depositories sufficient to meet the needs of joint-stock companies in implementing shareholder and investment fund registers.

9.10 PROTECTION OF SHAREHOLDER RIGHTS

9.10.1. In the interest of protecting shareholder's rights:

all common shares of an open joint-stock company shall entitle their holders to equal rights and shall pay equal dividends, regardless of their date of issue;

an annual shareholders' meeting of an open joint-stock company shall be held within 120 calendar days of the end of the fiscal year. In addition, the joint-stock company's balance sheet, profit and loss records (annual report), and report of the auditing commission on the results of its annual review, all of which are presented at the annual shareholders' meeting, shall be approved by the joint-stock company's board of directors no later than 60 days after the end of the fiscal year. Should the board of directors fail to approve the JSC's balance sheet, then the balance sheet shall be turned over to the tax inspector's office, which shall commission an audit at the JSC's expense.

9.10.2. Decisions relating to the following actions may be made only by a shareholders' meeting, at which the holders of three-quarters of the company's common shares are either present in person or represented by duly appointed proxy, and consent to the decision:

changes or additions to the JSC's charter;

changes in the size of the JSC's charter capital;

except in instances of redemption of shares purchased by the company: any mortgaging, lease, sale, exchange or other alienation of any property which is indicated in the charter documents of the company; as well as cases where the size of a transaction or the value of property which is the object of a transaction exceeds 25 percent of the charter capital; or in cases where the JSC's auditing commission has not made any determination on approval of the transaction;

participation in holding companies, amalgamated enterprises and financial-industrial groups;

reorganization or liquidation of the JSC. This point applies to open JSCs, created in the process of privatization of state/municipal enterprises, if at the moment of the general meeting of shareholders not more than 25 percent of the company's shares are state/municipally-held.

9.10.3. Any limitations or conditions on the sale by shareholders of shares in an open JSC owned by them are forbidden.

9.10.4. The board of directors of an open JSC is elected at a meeting of shareholders and shall consist of not less than seven members, and for JSCs with more than ten thousand shareholders, not less than nine members. during elections to the board of directors, each share shall carry a number of votes equivalent to the number of board members being elected. During voting, each shareholder has the right to cast part or all of the votes to which he is entitled from each share held by him, for one or several candidates to the board of directors. Those candidates receiving the greatest number of votes shall be elected. to the board of directors.

Each member of the board of directors shall have one vote at meetings of the board of directors. Shareholders who are employees of the JSC may not comprise more than one-third of the board of directors of that company.

9.10.5. Shares of a JSC which are held by the JSC which issued them shall not participate in voting at the general meeting of shareholders. A quorum shall be determined without consideration of such shares.

9.10.6. An open joint-stock company may not be reorganized into a closed joint-stock

company or a limited liability association.

9.10.7. A joint-stock company is required to send to each shareholder, via registered mail, no later than 30 days before the meeting of shareholders:

written notice of the time and place the shareholders' meeting is to be held;

an agenda for the shareholders' meeting, approved by the board of directors;

information on shareholders' meeting agenda issues, including a ballot for elections to the board of directors and a ballot for elections to the auditing commission.

The procedure for preparing and conducting the general meeting of open joint-stock companies shall be approved by the Securities and Stock Exchange Commission of the President of the Russian Federation.

10. USE OF FOREIGN INVESTMENT

10.1 Foreign investors may participate in auctions (including voucher auctions), tenders, and may purchase privatization vouchers for use as a means of payment in the process of privatization; The Russian Ministry of Finance must be subsequently informed of these actions.

No additional permits from state committees, ministries, or departments of the Russian Federation, krais, oblasts, autonomous oblasts, or autonomous okrugs, or of the cities of Moscow and Saint-Petersburg are required for use of privatization vouchers by foreign physical or legal persons in the process of privatization.

In the conducting of transactions with foreign investors, the appropriate property funds (property administration committees) shall act as the sole and exclusive vendors of state and municipal properties.

If a foreign investor is the sole participant in an auction, tender, or investment tender, then an enterprise may be sold to him. In this case the appropriate property fund conducts a special appraisal of the property of the enterprise, according to a system approved by the Russian State Property Committee together with the Russian Ministry of Finance.

Participation by foreign investors in the privatization of objects falling into the following categories shall be permitted only by decision of local authorities or organs authorized by them: trade organizations, food industry, service industry, and small industrial, construction, and road transport enterprises (with an average payroll of less than 200 persons, or with assets of less than 1 million rubles, as of 1 January 1992).
Decisions to admit foreign investors into participation in the privatization of the following categories of enterprises shall be rendered only by the Government of the Russian Federation or by the governments of the republics within the Russian Federation (depending on the type of state property), simultaneously with a decision on the feasibility of privatization of such enterprises: objects and enterprises of the defense industry (where the amount of their sales is more than 30 percent defense-related); oil and gas industry; mining and processing of strategic ores and raw materials, precious and semi-precious stones, precious metals, radioactive and rare-earth elements; transportation and communications enterprises as listed in section 2.2 of this program. In addition, after the voucher (stock) auction (tender), the organizers shall forward information on the foreign winning bidder to the Government of the Russian Federation and to the Federal Counterintelligence Service of the Russian Federation. The Federal Counterintelligence Service of the Russian Federation shall have the right within one month to present grounds for denying the acquisition by the foreign investors of shares, interests, or property. On the basis of these findings the Government of the Russian Federation may pass an appropriate ruling.

The use of foreign investments in the privatization of state and municipal enterprises

located within closed territories, except as provided by rulings of the Government of the Russian Federation.

No other restrictions shall be placed on the participation of foreign investors in privatization.

10.2. Settlements with foreign investors (residents and nonresidents) in the conducting of transactions shall be executed in the currency of the Russian Federation or in privatization vouchers.

10.3. Foreign individuals not registered as entrepreneurs in their country of origin, shall be recognized as foreign investors as regards their participation in privatization.

11. MUTUAL RELATIONS OF STATE PRIVATIZATION ORGANS, AND THEIR RELATIONS WITH OTHER STATE AUTHORITIES AND WITH BUDGETS OF ALL LEVELS.

11.1. Unless otherwise provided by current privatization legislation, property funds, acting in accordance with accordance with the Regulation on the Russian Federal Property Fund (property fund), approved by Decree No 2173 of the President of the Russian Federation dated 17 December 1993, shall be the vendors of state/municipal enterprises and other state-owned objects.

In regions where property funds do not operate, their functions shall be carried out by the appropriate property administration committees.

The right of sale of federal property being privatized (with the exception of enterprises with a charter capital greater than 500 million rubles) shall belong to the Property Funds of republics, krais, oblasts, autonomous oblasts, autonomous okrugs, cities of Moscow and Saint-Petersburg (and other major cities -- upon approval of the Russian Federal Property Fund).

11.2. From the moment a decisions taken either by the worker's collective or by the appropriate property fund to privatize an enterprise, any powers delegated to a ministry, administration, or local authority become invalid, with the exception of the right to execute contracts with the upper management of the enterprise being privatized.

11.3. Russian Federation ministries and departments shall develop recommendations connected with the particularities of privatization in their fields; they shall corroborate such recommendations with the Russian Federation State Committee for Antitrust Policy and Support of New Economic Structures, and submit them to GKI of Russia, unless otherwise provided in section 6 of this Program.

The GKI of Russia shall develop recommendations on the procedure for privatization of objects and enterprises of various fields, as indicated in section 6 of this Program, taking into account the opinion of Russian Federation State Committee for Antitrust Policy and Support of New Economic Structures.

11.4. In order to exercise the powers of an owner at shareholder meetings of joint-stock companies whose share packages are secured in state property, or in cases where a decision has been taken to issue "golden share" (Zolotye Aktsii), the property administration committees on the appropriate levels may recruit representatives from the relevant Russian Federation ministries or departments to represent such ministries or departments. Representatives of the administration of and employees of joint-stock companies may not act as representatives of the state at shareholder meetings or on the board of directors.

11.5. Privatization organs of the Russian Federation (property administration committees and property funds) shall conduct the privatization of federally-owned objects without the additional consent of any state authorities or departments of the Russian Federation, with the exception of those objects restricted in privatization in accordance with articles 2.1, 2.2, and 2.3 of this Program.

11.6. Local property administration committees and property funds shall maintain records and accountability on privatization, and shall present to statistical bureaus accounting information on the progress of the privatization. This shall be accomplished in the form established by the State Committee of the Russian Federation for Statistics, and GKI of Russia; and shall be financed at the expense of the State committee of the Russian Federation for Statistics. The enterprises and organizations shall bear responsibility for the validity of this information.

12. REQUIREMENTS FOR LOCAL PRIVATIZATION PROGRAMS.

12.1. Local privatization programs shall be developed by property management committees of the republics within the Russian Federation, krais, oblasts, autonomous oblasts, autonomous okrugs, cities (except cities subordinate to raions) raions (except raions within cities); and are approved by the appropriate local authorities, who are in turn within their rights to assign privatization targets to subordinate authorities and administrations (organs of local self-government).

12.2. Local privatization programs must be developed in accordance with this Program, and approved no later than 2 months after this Program's publication. Thereafter, local programs must be published in the press of the appropriate authorities and presented to GKI of Russia.

12.3. Local privatization programs must:

not contradict this Program, nor introduce additional limitations on the privatization of objects or enterprises;

ensure the complete fulfillment of the requirements and targets set forth in this Program.

Local privatization programs must include:

a listing of enterprises subject to privatization;

proposals for the privatization of enterprises in cases which require the permission of the Government of the Russian Federation and GKI of Russia;

a listing of objects which have been temporarily closed down and incomplete constructions which are state or municipally-owned, whose construction deadlines have not been met and which are subject to privatization;

targets for the privatization by local authorities of municipally-owned objects, with a breakdown by categories in accordance with the accounting figures defined by this Program; furthermore, these targets must include those mandatory targets set forth in the 1992 State Privatization Program, unless they have already been met;

a schedule for holding voucher auctions for all enterprises being transformed into open joint-stock companies;

a forecast for funding, including in the form of privatization vouchers.

12.4. The GKI of Russia, in collaboration with the State Committee of the Russian Federation for Statistics, shall determine the forms and time limitations for the presentation of accountability for the fulfillment of the targets set forth in this Program.

12.5. The Chiefs of Administration, and chairmen of the property administration committees and property funds at all levels shall bear personal responsibility for the execution of local privatization programs.

12.6. The GKI of Russia shall oversee the execution of local privatization programs.

13. METHODS FOR STIMULATING THE FULFILLMENT OF THE STATE PRIVATIZATION PROGRAM OF THE RUSSIAN FEDERATION.

In order to raise the interest level of the regions, enterprises, committees, and property management funds, which shall conduct privatization, the following shall be accomplished in the implementation of this Program:

enterprises being privatized under appropriate programs and on a competitive basis may be rendered state assistance and benefits. Furthermore, those enterprises who actively cooperated with the property funds in the complete and timely fulfillment of their privatization plan under standard conditions, shall have unconditional priority in receiving state aid and benefits;

regions shall be provided with funding with consideration for their fulfillment of state privatization plans. Regions which have not met the requirements of Russian Federation privatization legislation, including those regions failing to accept privatization vouchers, shall receive no financial assistance;

those subjects of the Russian Federation, as concerns their property, and appropriate local bodies of self-government, as concerns municipal property, who take a decision to sell a greater percentage of shares (property) for privatization vouchers than that minimum percentage set forth in this program shall have a priority right to obtain financial assistance and preferential credit treatment from federal authorities during the creation of the federal budget;

the GKI of Russia and the Russian Federal Property Fund shall have the right to pay bonuses from funds realized from privatization, except funds realized from the sale of former military property (that which is under the operational command of the Armed Forces of the Russian Federation, The Federal Counterintelligence Service of the Russian Federation, the Ministry of Internal Affairs of the Russian Federation, and other ministries and administrations of the Russian Federation) in an amount not less than ten percent of the funds remaining at their disposal, to employees of the following: the State Committee of the Russian Federation for Antitrust Policy and the Support of New Economic Structures and its territorial administrations; sectorial ministries, committees, and administrations; local property committees and funds. These employees shall be those who have achieved the best results in the implementation of this program. The bonuses shall be paid without limiting the salaries of the staffs of the above-listed state administrative bodies.

Enterprises involved in the manufacturing sector, and whose charter capital consists of less than 25 percent state property (except those listed in section 2.1 and point 2.2.6), shall enjoy preference in the receipt of foreign technical assistance and foreign credits, unless otherwise specified by international (intergovernmental) agreement.

Monies and valuables, presented as foreign technical assistance, and foreign credits, allocated for privatization support in the Russian Federation, shall be exempt from any taxation, as well as from customs tariffs and fees.

14. THE PARTICULARITIES OF PRIVATIZATION IN THE REGIONS.

14.1 Property management committees and property funds of subjects of the Russian

Rural raions	Sales of objects of trade, food industry, and community services at commercial tenders, with a preservation of the form of the enterprise for up to five years, and with annual subsidies to the privatized enterprises
Regions which achieved the best .esults in the conducting of privatization (per the list approved by the Government of the Russian Federation)	All decisions on the privatization of objects listed in point 2.2 (except 2.2.4, 2.2.5, 2.2.6, 2.2.12, 2.2.15, 2.2.21 of the Program) shall be taken directly by the property management committees of republics, krais, oblasts, autonomous oblasts, autonomous okrugs, cities of Moscow and Saint-Petersburg without the permission of the Government of the Russian Federation.

14.5. The privatization of sanatorium/resort and tourist/excursion objects in the Kavkazsie Mineralnye Vody region shall be conducted in accordance with the Decree of the President of the Russian Federation.

15. PROVIDING INFORMATION ON THE PROCESS OF PRIVATIZATION

15.1. At the regional level, property management committees shall be required to allocate no less than 10 percent of their earnings from privatization for information and clarification.

15.2. The GKI of Russia, the Russian Federal Property Fund, and local property management committees and property funds and shall be responsible for publicity, clarification, information, and education tasks.

The above organs, in conducting privatization, shall be responsible for publishing:
in newspapers:

information on the substance of privatization, the role of privatization vouchers and means of using them, voucher auctions and investment funds.

in the privatization bulletin "The Russian Federal Property Fund Bulletin", which is jointly published at their own expense by the Russian Federal Property Fund and GKI of Russia: information on the progress of privatization, including voucher auctions, the time and place they are to be held, and on enterprises being offered at them.

in special mass-produced brochures: schedules for holding voucher auctions, information on the role of privatization in centers and at sites, the use of privatization vouchers, the manner for acquisition of shares in enterprises being privatized, on investment funds, and on the progress of holding voucher auctions.

15.3. The GKI of Russia and the Russian Federal Property Fund, and property funds and committees at the local level shall provide for the broadcast on television and radio of:
reporting in news programs on a regular basis of the progress of sales for privatization vouchers, and about the more significant objects being offered for sale;
regular broadcasts of information on future sales.

15.4. All the mass media which receive subsidies from budgets on all levels are required to give space or air time of a value up to ten percent of such subsidies to reporting on object being privatized on all levels of ownership.

15.5. The GKI of Russia, in collaboration with the Russian Federal Property Fund and other interested organizations must provide for gratis publication in the "Bulletin of the Russian Federal Property Fund" of announcements on auctions and investment tenders to be held.

16. SOCIAL WELFARE FOR EMPLOYEES OF ORGANS CONDUCTING PRIVATIZATION

16.1 In the interest of increasing the workplace prestige at organs conducting privatization, and of raising the interest level of their employees in performing professionally:

A mandatory state personal insurance program shall be set up, to be funded from budgets at all levels and from proceeds from privatization:

they shall be provided with means for personal protection per a list approved by the head of the privatization organ with the assent of the Ministry of Internal Affairs of the Russian Federation, purchased from the funds of the organs conducting privatization, and organize training in the use of those means.

16.2 It shall be established that:

upon the liquidation of property management committees and property funds at all levels, their employees shall be provided with a severance pay in an amount equal to one year's wages, which shall be paid from the appropriate budgets;

should a staff member die in the line of duty, his family shall receive a lump-sum payment in an amount equal to two year's wages of the deceased, which shall be paid from the appropriate budget;

should an employee receive serious injuries, which result in permanent disability, a lump-sum payment shall be made to him in an amount equal to one year of his wages, and for 10 years his pension shall be supplemented to the level of his former salary. This shall be paid from the appropriate budget.

Should an employee receive less serious injuries, a lump-sum payment shall be made to him equivalent to five months of his wages. This shall be paid from the appropriate budget.

Should an employee's property be damaged in the line of his duty, full compensation shall be paid from the appropriate budget, with subsequent recompensation to the budget to be made by the offender.

17. PRIVATIZATION AND STRUCTURAL POLICY

17.1 Certain procedures and conditions shall apply for the provision on a competitive basis of the following special purpose credits to firms being privatized, and which are involved in comprehensive state programs:

for the replenishment of turnover capital for investment needs;

for military industry conversion programs;

for environmental protection;

for other needs, as determined by the government of the Russian Federation, including import subsidies funded from centralized resources.

The procedure for conducting special competitions for preferred credits is defined by a

* Standards for the allocation of proceeds from privatization to the appropriate property funds and committees for the management of property are in effect from 1 January 1994

** Funds are allocated in accordance with conditions developed by the appropriate ministries, whereupon one percent of these funds are used as incentive for the organizers of the privatization process

*** Not less than 50 percent of the proceeds from privatization received by the GKI of Russia must be chanelled into the holding of voucher auctions. If, after voucher auctions and voucher investment tenders are held, insufficient funds remain for remittance into privatization bodies according to these standards, then the shortfall shall be compensated from the local budget.

Administration of these funds shall be carried out by a combined group consisting of representatives from the GKI of Russia and the Russian Federal Property Fund.

APPENDIX II

THE INTERREPUBLIC PROGRAM OF PRIVATIZATION OF STATE AND MUNICIPAL ENTERPRISES IN RAIONS OF THE FAR NORTH AND SIMILAR REGIONS

The Interrepublic Program of Privatization of State and Municipal Enterprises in Raions of the Far North and Similar Regions, which was developed in accordance with the Law of the Russian Federation "On the Privatization of State and Municipal Enterprises in the Russian Federation" and the Resolution of the Supreme Soviet of the Russian Federation "On the Implementation of the State Program of Privatization of State and Municipal Enterprises in the Russian Federation in 1992," establishes the goals of privatization, delineates the circumstances for granting privileges under privatization, and determines the general conduct of, as well as restrictions on, the privatization of objects and enterprises located in the specified regions.

The Program is an integral part of the State Program of Privatization of State and Municipal Enterprises in the Russian Federation and supplements the latter as concerns the creation of a system of measures which take into account the peculiarities of implementing privatization in the Far North and in similar regions.

1. Provisions of the Program apply to state and municipal enterprises located in the following territories:

Republic of Altai -- the Kosh-Agachkii and Ulaganskii raions;

Republic of Buryatiya -- the city of Severobaikal'sk; the Bauntovskii, Kurumkanskii, Okinskii, Muiskii, and Severo-Baikal'skii raions;

The Republic of Komi;

Republic of Kareliya -- the city of Kostomuksha; the Belomorskii, Kemskii, Loukhskii, Kaleval'skii, and Senezhskii raions;

The Republic of Sakha (Yakutiya);

Krasnoyarskii Krai -- the Evenkiiskii and Taimyrskii (Dolgano-Nenetskii) okrugs; the cities of Igarka, Lesosibirsk, Noril'sk, and Eniseisk; the Boguchanskii, Eniseiskii, Kezhemskii, Motyginskii, Severo-Eniseiskii, and Turukhanskii raions;

Primorskii Krai -- the city of Dal'negorsk; the Dal'negorskii, Kavalerovskii, Ol'ginskii, and Terneiskii raions; the labor posyolok of Vostok; the Boguslavetskii, Vostretsovskii, Dal'ne-Kutskii, Ismailikhskii, Mel'nichnyi, Roshchinskii, and Taezhnenskii rural soviets of the Krasnoarmeiskii raion;

Khabarovskii Krai -- the cities of Amursk, Komsomol'sk-na-Amure, Nikolaevsk-na-Amure, and Sovetskaya Gaban'; the Ayano-Maiskii, Okhotskii, Vanenskii, Verkhnebupeinskii, Komsomol'skii, Nikolaevskii, im. Poliny Osipenko, Sovetsko-Gavanskii, Solnechnyi, Tururo-Chumikanskii, and Ul'chskii raions; the Amurskii raion, including the labor posyolok of El'ban; the Voznesenskii, Paalinskii, Achanskii, Dzhuenskii, and Al'minskii rural soviets;

The Chukotskii autonomous okrug;

Amurskaya Oblast -- the cities of Tynda and Zeya; the Zeiskii, Selendzhinskii, and Tydinskii raions;

The Arkhangel'skaya Oblast;

Irkutskaya Oblast -- the cities of Bratsk, Bodaibo, Ust'-Ilimsk, and Ust'-Kut; the Bodaibinskii, Bratskii, Kazachinsko-Lenskii, Katangskii, Kirenskii, Mamsko-Chuiskii, Nizhneilimskii, Ust'-Ilimskii, and Ust'-Kutskii raions;

The Kamchatskaya Oblast;

The Magadanskaya Oblast;

The Murmanskaya Oblast;

Permskaya Oblast -- the Komi-Permyatskii autonomous okrug; the Gainskii, Kosinskii, and Kochevskii raions;

The Sakhalinskaya Oblast;

Tomskaya Oblast -- the cities of Kedrovyi, Kolpashevo, and Strezhevoi; the Aleksandrovskii, Bakcharskii, Verkhneketskii, Cargasokskii, Kolpashevskii, Krivosheinskii, Molchanovskii, Parabel'skii, Tegul'detskii, and Chainskii raions;

Tyumenskaya Oblast -- the Yamalo-Nenetskii and Khanty-Mansiiskii autonomous okrugs; the Uvatskii raion;

Chitinskaya oblast -- the Kalarskii, Tungiro-Olekminskii, and Tungokochinskii raions;

All islands in the Northern Artic Ocean and its seas, as well as islands in the Bering Sea and the Sea of Okhotsk.

Requirements set forth by this Program are binding for state governing and administrative bodies of the Russian Federation, republics within the Russian Federation, krais, oblasts, and autonomous oblasts, and for organs of local self-government, located in raions of the Far North and in similar regions.

Issues on the privatization of objects of property that have not been settled by this Program are governed by the provisions of the State Program of Privatization of State and Municipal Enterprises in the Russian Federation and by local privatization programs.

2. SPECIFICS OF THE GOALS OF PRIVATIZATION

In addition to the main goals of privatization in the Russian Federation, which are set forth in section 1 of the State Program of Privatization of State and Municipal Enterprises in the Russian Federation, the following are supplementary goals of privatization in raions of the Far North and similar regions:

to achieve a sensible union of the traditional economic activities of the peoples of the North with industrial production;

to promote the sensible employment of the population and the social development of the regions;

to create real conditions for the establishment of ownership rights for the population living in raions of the Far North and similar regions, and also for communal economic enterprise collectives and isolated inhabitants among the sparse peoples of the North.

3. SUPPLEMENTARY RESTRICTIONS ON PRIVATIZATION

3.1 It is forbidden to privatize cultural objects and enterprises, as well as objects and enterprises of amateur and professional sports, located in the arctic zone of the Far North, in places of habitation and economic activity of the sparse peoples of the North, or in mining posyoloks.

3.2 With regard to enterprises, and organizations and their organizational subdivisions held in the assets of enterprises, performing work involving expeditionary tours of duty in

and similar regions, including trucking enterprises, as well as enterprises engaged in freight traffic involving expeditionary tours of duty, decisions on privatization shall be made directly by the GKI of Russia based on the conclusions of the State Committee of the Russian Federation for Socioeconomic Development of the North and the appropriate sectoral ministries, departments, and committees.

3.3 The participation of foreign investors in the privatization of objects and enterprises involved in commerce, the food services industry, and basic services, and also of small industrial, construction, and motor vehicle enterprises (with a net value, as of 1 January 1992, of less than 1 million rubles), is permitted only by a decision of local self-governing bodies, or, in places of habitation of the sparse peoples of the North, with the consent of regional associations of these peoples.

A decision to allow foreign investors to participate in the privatization of objects and enterprises in the fuel and energy complex or objects and enterprises for the extraction and processing of ores of precious and semiprecious stones, precious metals, and radioactive and rare-earth elements must be made by the Government of the Russian Federation or the governments of the Republic of Altai, the Republic of Kareliya, the Republic of Buryatiya, and the Republic of Sakha (Yakutiya) (depending on the type of ownership) and must be made simultaneously with the initial decision to allow privatization of these objects and enterprises.

3.4 A decision to privatize objects and enterprises involved in the traditional economic activities of peoples of the North must be made with the consent of both regional associations of the sparse peoples of the North and representatives of collectives of these peoples.

Objects and enterprises involved in the traditional economic activities of peoples of the North shall be defined as (i) those enterprises for which not less than half the members of the work collective belong to a sparse ethnic community related to the indigenous population of a given territory; (ii) those enterprises located in places of habitation and economic activity of the sparse peoples of the North and using as raw materials secondary products of traditional professions (reindeer breeding, hunting, fishing and hunting of sea animals, gathering of wild plants), as well as those objects of the industrial infrastructure serving the given enterprises, including enterprises for the processing and preservation of buckskin, velvet antlers, and by-products, and the processing of fish, sea animals, and sea products, enterprises and works for the tanning of deer hides and the processing and preparation of fur products, enterprises for the manufacture of folk arts and crafts, the tailoring of fur clothing, and the cobbling of shoes, and enterprises providing raw materials for the production of medical biological compounds.

4. ENTERPRISES SUBJECT TO MANDATORY PRIVATIZATION

The following are subject to mandatory privatization:

enterprises working with small reserves of mineral deposits, including those previously abandoned, which are considered substandard, with the exception of enterprises for the extraction of precious metals and precious stones;

enterprises in all areas of the national economy which have been temporarily shut down, with the exception of enterprises in the precious metals and stones industry, including

property remaining after the liquidation of an enterprise.

5. SPECIFICS OF CHOOSING THE METHOD OF PRIVATIZATION

In determining the method of privatization, the following factors are considered:

the size of the enterprise (the average manpower and the net value of fixed assets), its socioeconomic significance for attaining goals of both national and local importance;

special characteristics of the enterprise being privatized; the advisibility of maintaining the line of activity of the enterprise; ecological conditions in the region in which the enterprise operates; the degree to which enterprises either hold a monopoly, in relation to consumers of their products and services, or are affected by a monopoly, in relation to the suppliers of material resources, in regions where they operate.

investment requirements, including foreign investment;

the opinion of the work collective of the enterprise being privatized;

the opinion of regional associations of the sparse peoples of the North and of representatives of their economic collectives, if the objects of privatization are directly located in places of habitation and economic activity of these peoples.

6. SUPPLEMENTARY METHODS OF PRIVATIZATION

6.1 When enterprises involved in the traditional economic activities of the peoples of the North (with a net value of fixed assets, as of 1 January 1992, of greater than 1 million rubles) are privatized by means of transforming them into open joint-stock companies, all members of the work collective of an enterprise shall be granted the right to receive gratuitous common (voting) shares constituting up to 50 percent of the charter capital. These shares are alloted among the members of the work collective by a decision of its board (conference).

The balance of the shares shall be distributed in the following manner:

29 percent -- for sale in closed voucher auctions, the procedure for the holding of which is determined by the Government of the Russian Federation;

the remaining shares -- for sale for money at auction among inhabitants of republics within the Russian Federation, krais, oblasts, and autonomous okrugs, wholly or partially associated with raions of the Far North. An enterprise employee shareholder fund (EESF) is not formed in this case.

6.2 When enterprises involved in the traditional economic activities of the peoples of the North (with a net value of fixed assets, as of 1 January 1992, of less than 1 million rubles) are privatized, a partnership which comprises not less than half the members of the total workforce of an enterprise shall have the right to acquire the enterprise for the residual net value within a period of three months after the adoption of the privatization plan of the given enterprise.

If the workers fail to acquire the enterprise, privatization shall be carried out at auction or on a tender basis in accordance with the legislation of the Russian Federation.

6.3 Stock in enterprises in the oil, oil-refining, and petroleum-products industries may

be sold to the population of oil-producing regions associated with the sparse peoples of the North, or to members of work collectives of enterprises and associations for oil transport, in ad hoc closed check auctions conducted in accordance with Resolutions adopted by the GKI of Russia. It is established that specialized voucher investment funds, in which are accumulated the privatization vouchers of citizens in the categories mentioned above, may act as representatives of these citizens in such auctions. In this case, these special funds shall bear the responsibility for proving to the vendors - the appropriate property funds or their representatives - that their shareholders (not counting the establishers) are all citizens in the above-mentioned categories.

6.4 For the privatization of enterprises involved in commerce, the food services industry, or basic services located in isolated raions of the Far North or in similar regions (corresponding to a list developed by the State Committee of the Russian Federation for the Socioeconomic Development of the North and approved by the GKI of Russia), the appropriate committees for the management of property may decide to permit sale of these enterprises at tenders with the following mandatory conditions of the sale: that the output level of specific types of merchandise, work, and services shall be maintained for a period of three years, taking into account the existing demand; that an interruption in the work of the object being privatized for a period of greater than two months after the purchase/sale and (or) for a total of more than six months in a calender year shall be forbidden; that changes in the work schedule of the object being privatized which curtail the operations of the object shall be approved by the local administration; and also that one of the following conditions shall be fulfilled by the buyer:

that they not allow a curtailment of production (service) volume;

that they adhere to established ecological regulations, and also that they cut back on environmental damage;

that they finance the construction of objects of environmental protection and objects of the social infrastructure;

that they maintain the number of job positions, including reserving jobs for representatives of the sparse peoples of the North;

that they guarantee a required amount of investment in the development of production.

6.5 The privatization of objects and enterprises in the mining industry that are temporarily shut down shall be carried out exclusively at investment tenders for money with discounts of 50 percent and with the imposition of mandatory conditions of investment in environmental protection works and of reopening of the enterprises within six months of the acquisition of ownership.

6.6 The privatization of enterprises acknowledged as ecological hazards, corresponding to a list compiled by the Ministry of Environmental and Natural Resources Protection of the Russian Federation and the State Committee of the Russian Federation for Socioeconomic Development of the North and approved by the GKI of Russia, shall proceed only at commercial or investment tenders (for privatization vouchers before 1 July 1994, and for money after 1 July 1994) with the mandatory conditions of investment in improving the ecological condition of the environment.

6.7 When state and municipal enterprises located in raions of the Far North and in similar regions are privatized, in response to the proposal of a work collective and the assent of local self-governing bodies, it shall be permissible to include social, cultural, and basic services objects that are part of the assets of an enterprise in the aggregate of property being privatized.

6.8 When airports of regional and local importance, transport enterprises serving the arctic zone of the Far North, sea ports of regional and local importance, and port areas are transormed into open joint-stock companies, and when a decision is taken to hold share parcels in state/municipal ownership, the object or enterprise in question shall be brought under the control of governing bodies of subjects of the Russian Federation.

6.9 When state and municipal enterprises located in raions of the Far North and in similar regions are privatized, members of the work collectives of these enterprises and persons equivalent to them shall be entitled to priveleges specified by the State Program of Privatization of State and Municipal Enterprises in the Russian Federation depending on the chosen method of privatization, and shall also be entitled to priveleges set forth by this Program.

6.10 In order to determine the amount of compensation given to work collectives that did not receive ownership rights as the result of a tender, the minimum monthly wage shall be applied, as established by the legislation of the Russian Federation, calculated for one worker taking into account the correction coefficient of the raion and a percentage increase in salary.

6.11 The right to priveleged acquisition of shares in open joint-stock companies being formed from enterprises located in raions of the Far North and in similar regions shall be granted to the former employees of an enterprise whose working tenure in the enterprise being privatized is no less than five years for men and three and a half years for women.

6.12 When enterprises whose production is seasonally dependent and who are involved in the primary processing of agricultural raw materials, fish, and ocean products are privatized in accordance with local programs, work collectives of these enterprises shall, during the period of high-volume receipt of these raw materials and corresponding increase in the level of working capital, be granted extensions of regularly scheduled payments for objects of privatization until the completion of settlements for sales of their products, but these extensions shall be for no longer than six months.

6.13 When enterprises in the mining industry located in raions of the Far North and in similar regions are privatized, priveleges specified by this Program for members of work collectives shall apply only to former employees of these enterprises whose working tenure in the enterprise is no less than five years for men and three and a half years for women, irrespective of their place of residence, and to those members of prospectors' artels leasing the property of these enterprises, who have worked in them for no less than five seasons.

6.14 If an enterprise is situated outside raions of the Far North and similar regions, but performs work by expeditionary tours of duty amounting to not less than 75 percent of

the general volume of performed works (services) in these areas, then members of the work collective of the enterprise shall be granted priveleges given to collectives of enterprises located in raions of the Far North and in similar regions. When separate subdivisions of an enterprise operate in the system of expeditionary tours of duty, then workers of a given subdivision shall be granted priveleges specified for workers in raions of the Far North and in similar regions if that subdivision obtains the status of a juridical person in the process of privatization of the enterprise. These priveleges shall not be extended to other subdivisions of the enterprise.

7. MEASURES FOR SOCIAL PROTECTION OF THE POPULATION DURING THE PROCESS OF PRIVATIZATION

7.1 Proceeds into the Federal Fund for Enterpreneurial Support can also be used to grant lump-sum aid packages for the resettlement of people moving to regions of Russia where there is an insufficient work force, or to a village owing to a loss of work.

7.2 If the reservation of job positions for the sparse peoples of the North is made a condition of privatization, then associations of those peoples are granted the right to monitor the hiring and employment of individuals from among them in both enterprises engaged in traditional economic activities and enterprises engaged in other activities located in places of habitation and economic activity of the sparse peoples of the North.

8. THE PROCEDURE FOR RELATIONS BETWEEN STATE BODIES IMPLEMENTING PRIVATIZATION

8.1 For a decision on the privatization of state- or municipally-owned property in places of habitation and economic activity of the sparse peoples of the North, the opinion of regional associations of these peoples representing the interests of ethnic groups shall be considered.

8.2 Ministries and departments of the Russian Federation shall develop recommendations for the accounting of specific features of enterprises, located in raions of the Far North and in similar regions, in the process of privatization and assumption of ownership powers. They shall approve these regulations with the State Committee of the Russian Federation for Antitrust Policy and Support of New Economic Structures, and shall present them to the GKI of Russia.

8.3 When a deficit exists in the finances of bodies implementing privatization (property management committees and property funds) in areas located in raions of the Far North and in similar regions, the GKI of Russia and the Russian Federal Property Fund shall render them financial assistance.

9. FORMATION OF PURPOSE-ORIENTED FINANCIAL FUNDS FOR THE PROCEEDS FROM PRIVATIZATION

9.1 Monetary proceeds received from privatization and put at the disposal of the appropriate local self-governing bodies, apart from funds formed in accordance with the State Program of Privatization of State and Municipal Enterprises in the Russian Federation, shall be channeled into the formation of the following purpose-oriented funds for raions of the Far North and similar regions:

the fund for support of the unemployed and those desiring to move to regions of Russia where there is an insufficient work force or to pursue agricultural activity. Proceeds of this fund shall help pay for departure and resettlement of migrants;

the fund for environmental protection measures;

the fund for economic and cultural development of the sparse peoples of the Far North.

9.2 The procedure for formation and allocation of purpose-oriented funds, and also the level of proceeds channeled for the above purposes, shall be determined by the Government of the Russian Federation.

10. REQUIREMENTS ON LOCAL PRIVATIZATION PROGRAMS

10.1 Local programs of privatization of state and municipal enterprises located in raions of the Far North and in similar regions shall be developed by the appropriate property management committees of republics within the Russian Federation, krais, oblasts, the autonomous oblast, autonomous okrugs, cities (except those subordinate to regions), and raions (except those in cities). The programs shall be implemented by the appropriate local self-governing bodies, taking into account the opinions of associations of the sparse peoples of the North on those parts of the programs concerning their active lives.

10.2 Local privatization programs must be developed (refined) in accordance with the requirements of this Program and approved (reapproved) no later than one month after their publication. Local privatization programs must be published in the printing offices of the appropriate local self-governing bodies and must be presented to the GKI of Russia.

10.3 Local privatization programs must:

not contradict the State Program of Privatization of State and Municipal Enterprises in the Russian Federation or this Program;

not include proposals for the privatization of enterprises which are not subject to privatization and not introduce supplementary restrictions on the privatization of enterprises;

include listings of specific enterprises (groups of enterprises) subject to privatization, with the delineation of enterprises located in places of habitation and economic activity of the sparse peoples of the North;

include forecasts for the receipt of proceeds from privatization, as well as the priority and destinations for the channeling of these proceeds;

consider the nonuniformity of the territories inside administrative and territorial units with respect to natural and climatic conditions, the extent of their assimilation and their transportational accessibility;

consider the possible social ramifications of liquidating ineffective enterprise, most of all in small towns and population centers with single-sector production;

include definite measures for demonopolization and creation of a competitive atmosphere, in aggreement with the appropriate territorial administrators of the Committee of the Russian Federation for Antitrust Policy and Support of New Economic Structures, and measures for social protection of the population, support and development of entrepreneurship, and environmental protection, and to use for this the resources of extrabudgetary funds and foreign investments.

Property management committees of republics within the Russian Federation, krais, oblasts, the autonomous oblast, autonomous okrugs, cities, and raions (except raions in cities), with the consent of the appropriate local self-governing bodies, can introduce changes into republican and local privatization programs.

Supervision of the fulfillment of local programs of privatization of state and municipal enterprises located in raions of the Far North and in similar regions shall be entrusted to the GKI of Russia and the State Committee of the Russian Federation for Socioeconomic Development of the North.

This document is the last version
of the Law of the Russian Federation
"On Health Insurance of the Citizens
of the Russian Federation" which includes
all amendments and corrections to
the 1991 Law by the 1993 Law
of the Russian Federation
"On the Amendments and Additions
to the Law of the RSFSR "On Health
Insurance of the Citizens in the RSFSR".

Unofficial translation

THE LAW
OF THE RUSSIAN FEDERATION
ON HEALTH INSURANCE OF THE CITIZENS OF THE RUSSIAN FEDERATION

This Law defines legal, economic and organizational foundations of the health insurance of the Russian Federation population. The Law is aimed at strengthening the motivation and responsibility of the population and government, enterprises, institutions, organizations in the cause of citizens' health protection in new economic conditions and at ensuring the constitutional right of the Russian Federation citizens to health protection.

Chapter 1. Basic Principles

Article 1. Health Insurance

Health insurance is a form of social protection of the interests of the population in the sphere of health protection.

The goal of health insurance is to guarantee, in case of insured accident, that the individual will receive medical care paid for by the accumulated installment premiums, as well as to finance preventive services.

Health insurance is to be carried out in two forms: compulsory and voluntary.

Compulsory health insurance is part of the state social insurance and provides equal abilities for all citizens of the Russian Federation in obtaining medical and medicinal care, which is funded through compulsory medical insurance moneys in the volume and on terms, which conform compulsory health insurance programs.

Voluntary health insurance is carried out on the basis of

Programs of Voluntary Health Insurance and provides the population with any additional medical and other services not covered in the Programs of Compulsory Health Insurance.

Voluntary health insurance can be both collective and private.

Article 2. Subjects of Health Insurance

The subjects of health insurance are: citizens, insurant, health insurance company, medical facility.

Under compulsory health insurance the insurants are: for the non-working population - Councils of Ministers of republics inside the Russian Federation, governmental bodies of autonomous oblast, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg, local administration; for the working population - enterprises, institutions, organizations, self-employed individuals and individuals of free occupation[1] (thereafter called "enterprises").

Under voluntary health insurance the insurants are legally capable citizens and (or) enterprises representing citizens' interests.

Health insurance companies are legal entities practicing health insurance and possessing an official right (license) to deal in health insurance.

Medical facilities in the framework of health insurance are license-holding medical establishments, scientific research and medical institutes, other institutions offering medical services, as well as persons practicing medicine both individually and in groups.

Chapter 2. The System of Health Insurance

Article 3. The Object of Voluntary Health Insurance

The object of voluntary health insurance is the insurance risk connected with the cost of providing medical assistance in the event of insured accident.

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[1] The "individual of free occupation" are those people engaged uncreative activities who are not members of their professional union.

Article 4. The Health Insurance Contract

Health insurance is carried out in the form of a contract between the subjects of health insurance. The subjects of health insurance are to fulfil their obligations under contract in accordance with the legislation of the Russian Federation.

The health insurance contract is an agreement between the insurant and the health insurance company according to which the latter takes upon itself the obligation to organize and finance the provision to the insured individuals medical assistance of defined volume and quality or other services in the framework of the programs of compulsory and voluntary health insurance.

Health insurance contract should include:

- the names of the parties;
- the term of the contract;
- the number of the insured;
- the volume, timing and means of payment of the insurance premium;
- the list of medical services covered by the programs of compulsory or voluntary health insurance;
- the rights, obligations and responsibilities of the parties and other conditions which do not contradict the legislation of the Russian Federation.

The typical form of compulsory and voluntary health insurance contract, as well as the terms and conditions of the issue of contract are established by the Council of Ministers - Government of the Russian Federation.

Unless otherwise stated in the contract, a health insurance contract is considered effective immediately after the first premium is paid.

If the insurant stops being a legal entity due to liquidation or reorganization of the enterprise while the compulsory health insurance contract is still valid, the rights and obligations under the contract are transferred to its successor.

If the insurant is officially (in court) recognized as legally incapable or limited in legal capability while the voluntary health insurance contract is still valid, his rights and obligations under the contract are transferred to his guardian or trustee acting in the interests of the insured.

Article 5. Health Insurance Policy

Every citizen in whose name a health insurance contract was concluded or who independently concludes such a contract receives a health insurance policy. The health insurance policy is held by the insured individual.

The form of health insurance policy and the instructions how to fill it out are to be issued by the Council of Ministers - Government of the Russian Federation.

Health insurance policy is valid on the entire territory of the Russian Federation a swell as on the territory of other republics which signed the joint agreement on the health insurance of citizens.

Article 6. The Rights of the Citizens of the Russian Federation in the System of Health Insurance

Citizens of the Russian Federation have the right to:

- compulsory and voluntary health insurance;
- choice of the health insurance company;
- choice of the medical facility and physician in accordance with the contracts of compulsory and voluntary health insurance;
- receiving medical care on the entire territory of the Russian Federation, including that outside the place of permanent residence;
- bringing an action against the insurant, health insurance company, medical facility, including action for damages inflicted by the above mentioned parties, regardless of the fact whether or not this right is specifically indicated in the contract;
- getting back part of the premium paid in under the voluntary health insurance plan if this is stated in the contract.

Regulations of compulsory health insurance which are put forward in this Law and other official documents pertaining thereof are to be applied to the working citizens immediately after they sign the labor agreement.

The interests of the citizens are protected by the Councils of Ministers of the Russian Federation and republics within the Russian Federation, by the government bodies of autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg, local administration, professional, public and other unions (organizations).

Article 7. The Rights and Responsibilities of People Without Citizenship in the System of Health Insurance

On the territory of the Russian Federation people without citizenship have the same right and obligations in the system of health insurance as citizens of the Russian Federation.

Article 8. Health Insurance of the Citizens of the Russian Federation Abroad and Health Insurance of the Foreign Citizens on the Territory of the Russian Federation

Health insurance of the citizens of the Russian Federation abroad is carried out on the basis of bilateral agreements between the Russian Federation and foreign country the citizen is visiting.

Health insurance of foreign citizens temporarily living in the Russian Federation is carried out according to the regulations set up by the Council of Ministers of the Russian Federation - Government of the Russian Federation.

Foreign citizens enjoying the right of permanent residency in the Russian Federation have the same rights and obligations in the system of health insurance as citizens of the Russian Federation, unless otherwise stated in the international agreements.

Article 9. Rights and Obligations of the Insurant

The insurant has the right to:

- participation in all kinds of health insurance;
- free choice of insurance company;
- control over the fulfillment of health insurance contract;
- taking back part of the premium paid in to the insurance company under voluntary health insurance plan in accordance with the contract.

In addition to the rights indicated above, institutional insurants (enterprises) have the right to:

- allocation of financial resources out of profit or income of the enterprise for the purposes of voluntary health insurance of the employees.

The insurant is obliged to:

- conclude the contract of compulsory health insurance with a health insurance company;
- pay the installment premium on time in the way described by this Law and the contract of health insurance;
- take measures, as far as it is possible, against the events that may be dangerous to the health of the citizens;
- provide the insurance company with all the information required concerning the health of the individuals that should be insured.

Article 10. The Sources of Financing the Public Health Care System in the Russian Federation

The financial resources of public health care system in the Russian Federation are:

- funds from Republican (the Russian Federation) budget, budgets of he republica within the Russian Federation, and budgets of the local Councils of People's Deputies;
- funds of state and public organizations (amalgamations), enterprises and other economic agents;
- personal funds of the citizens;
- charitable donations and contributions;
- income on securities;
- loans of banks and other credit institutions;
- other sources not forbidden by the legislation of the Russian Federation and the republics within the Russian Federation.

These resources are used in the formation of funds for the state and municipal health care systems and funds for state system of compulsory health insurance.

Article 11. Moneys for the State and Municipal Health Care Systems

Moneys for the state and municipal health care systems are for realization of the state policy in health protection of the population. Councils of ministers of the Russian Federation and republics within the Russian Federation, government bodies of autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg, local administration determine the amount of funds allocated to state and municipal health care systems.

Moneys for the state and municipal health care systems are used as following:

- financing the development and implementation of earmarked programs put forward by the Councils of Ministers of the Russian Federation and republics within the Russian Federation, government bodies of autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg, local administration;
- provision of the professional training of the personnel;
- financing scientific research;
- upgrading medical facilities;
- subsidizing certain territories in order to equalize the condition of provision of medical care to the population under the compulsory health insurance;
- covering the cost of the most expensive types of medical services;
- financing medical facilities providing care for socially significant diseases;
- providing medical assistance in times of epidemics, in disaster zones, and in other cases of emergency.

Financial resources that haven't been spent during the current year cannot be taken away and are not taken into account in the formation of the next year's budget.

Article 12. Moneys for State System of Compulsory Health Insurance

Moneys for the state system of the compulsory health insurance are formed by the insurants' assignments for compulsory health insurance.

The Federal and territorial funds for compulsory health insurance are established as independent non-commercial finance

and credit institutions for implementation of the state policy in the sphere of compulsory health insurance.

The Federal fund for compulsory health insurance is established by the Supreme Soviet of the Russian Federation and carries out its activity in accordance with the legislation of the Russian Federation.

Territorial funds for compulsory health insurance are established by the Supreme Soviets of the republics within the Russian Federation, by the Soviets of People's Deputies of autonomous oblasts, autonomous okrugs, krays, oblasts,cities Moscow and St. Petersburg and carry out its activity in accordance with the legislation of the Russian Federation, republics within the Russian Federation and normative legislation acts of autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg.

Funds for compulsory health insurance aim to accumulate insurance premiums, to provide financial stability of the state system of compulsory health insurance and to equalize financial resources for it.

Moneys of funds for compulsory health insurance are the state property of the Russian Federation; they are not included into budgets or other funds, and can not be withdrawn.

The procedure of collecting insurance premiums for compulsory health insurance is worked out by the Government of the Russian Federation and approved by the Supreme Soviet of the Russian Federation.

Article 13. Taxation of Moneys Allocated for Health Care

Moneys allocated to citizens and legal entities for financing state and municipal system of health care are deducted from the taxable moneys.

Legal entities contributing part of their profit for the purposes of voluntary health insurance of their employees, their families and retired employees enjoy tax benefits of up to 10% of the amount contributed.

Chapter 3. The Activity of Health Insurance Companies

Article 14. Health Insurance Company

Health insurance companies are legal entities which are independent economic agents of any kind of ownership allowed by the legislation of the Russian Federation, which have capital fund large enough to provide resources for health insurance

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operations, and which organize their activity according to the legislation of the Russian Federation.

Health insurance companies are not part of the health care system.

Government bodies supervising the health care system and medical facilities cannot set up health insurance companies.

Government bodies supervising the health care system and medical facilities may own share of stock of health insurance company.

Their total share in any of the health insurance companies cannot exceed 10% of its capital fund.

Article 15. The Rights and Responsibilities of a Health Insurance Company

A health insurance company has the right to:

- free choice of medical facility for purposes of providing medical assistance to its clients according to health insurance contracts;
- participate in the accrediting of medical facilities;
- determine the size of voluntary health insurance premium;
- participate in determining the size of medical service fees;
- bring an action against medical facilities and/or its employees for material or moral damages inflicted to the insured person.

Health insurance company is obliged to:

- to carry out the health insurance activity on the non-commercial basis;
- contract medical facilities to provide medical assistance and care to the insured individuals in the framework of compulsory health insurance;
- contract any medical or other facilities to provide medical recreational, social and other services to their clients in the framework of voluntary health insurance;
- issue an insurance policy to the insured or the insurant immediately upon the conclusion of the contract;

- pay back part of the insurance premium to the insured or the insurant if this is envisaged by the contract;
- control the volume, quality and timing of the medical services granted according to the terms of the contract;
- defend the interests of the insured.

To ensure stability of insurance operations health insurance companies shall set up reserve funds.

Health insurance company cannot refuse to sign an compulsory health insurance contract unless it does not conform to the current health insurance regulations.

Article 16. The Issuing of Health Insurance Licenses

State license allowing the health insurance activity is issued by the Ministry of Finance of the Russian Federation and by its bodies according to the legislation of the Russian Federation.

Article 17. Health Insurance Premium

Health insurance premium is determined as a rate of payment for compulsory health insurance in the amounts sufficient for the implementation of the health insurance programs and for the operations of the health insurance company.

Compulsory health insurance premiums for the non-working population are paid by the Governments of the republica within the Russian Federation, governmental bodies of the autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg, local administration out of respective budgets according to the time schedule for each year; these payments should be adjusted to the price level changes.

In case local budget resources are not sufficient to pay the insurance premium in full, adequate amounts of money are to be provided from the upper-level budgets according to the order set up by the Council of Ministers - Government of the Russian Federation.

The size of premium tariff for compulsory health insurance for the enterprises, organizations, institutions and other economic entities of any type of ownership is established in percentage to the wage bill and should be approved by the Supreme Soviet of the Russian Federation.

Voluntary health insurance is financed through the profit of the enterprises and personal savings of the citizens by signing the contract.

The size of voluntary insurance premium is determined in the course of negotiations between the paries involved.

Article 18. The Taxation of Health Insurance Companies

Health insurance companies pay taxes according to the fiscal laws of the Russian Federation.

Article 19. Reorganization and Liquidation of Health Insurance Companies

Health Insurance companies are reorganized and liquidated according to the legislation of the Russian Federation.

Chapter 4. The Activity of Medical Facilities in the System of Health Insurance

Article 20. The Rights and Responsibilities of Medical Facilities.

Medical assistance and care in the framework of health insurance can be provided by formally accredited medical facilities with any kind of ownership. They are independent economic agents and operate according to the contracts with health insurance companies.

In accordance with their licenses medical facilities can participate in voluntary health insurance programs unless it prevents them from fulfilling their obligations under the compulsory health insurance programs.

Medical facilities that fulfil their obligations in the system of health insurance may offer medical services not connected with the health insurance system.

Medical facilities in the system of health insurance have the right to certify temporary disablement of the insured individuals.

Article 21. The Licensing and Accrediting of Medical Facilities

Licensing is the process of issuing a state permit allowing the medical facilities to deal in specified fields and to provide a certain range of services under compulsory and voluntary health insurance programs. Each medical facility regardless of its type of ownership has to obtain a license.

Licensing is performed by licensing committees set up by the government bodies, city and district local administration; members of such committees are chosen among representatives of government bodies supervising the medical care system, medical professional associations, medical facilities, public organizations.

The accrediting of medical facilities is the process of determining whether they are up to the accepted standards. Each medical facility regardless of its type of ownership has to be officially accredited.

The accrediting of medical facilities is carried out by the accrediting committees composed of the representatives of government bodies supervising the health care system, medical professional associations, health insurance companies.

The accredited medical facilities receive certificates issued by the Councils of Ministers of republics within the Russian Federation, government bodies of the autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg and local administration.

Article 22. Programs of Compulsory Health Insurance

The basic program of compulsory health insurance is worked out by the Ministry of health of the Russian Federation and approved by the Council of Ministers - Government of the Russian Federation. On the basis of the basic program the Councils of Ministers of the republics within the Russian Federation, government bodies of the autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg and local administration approve territorial programs of compulsory health insurance. The volume and quality of medical services provided according to the territorial programs cannot be any lower than described in the basic program.

Article 23. The Contract for the Provision of Medical Care (Medical Services) under the Health Insurance

A contract for the provision of medical care (medical services) is an agreement between a health insurance company and a medical facility according to which the medical facility has to provide the insured individuals with the medical care of stated volume and quality and within the specified period of time.

The relations between the parties are determined by the terms of contract. The contract must include the following:

- the names of the parties;
- the number of the insured;

- the types of medical care (medical services) provided;
- the cost of services and the system for their estimation;
- the system of control over the quality of services and over the use of financial resources;
- responsibilities of the parties and other terms unless they contradict the legislation of the Russian Federation.

Article 24. Tariffs for the Services in the System of Health Insurance

Tariffs for medical services under the compulsory health insurance are determined by the agreement between health insurance companies, the Councils of Ministers of the republics within the Russian federation, government bodies of the autonomous oblasts, autonomous okrugs, krays, oblasts, cities Moscow and St. Petersburg, local administration and medical professional associations. The tariffs should be sufficient to ensure profitability of the health insurance companies and a modern level of medical care.

Tariffs for medical and other services under the voluntary health insurance are determined in the course of negotiations between the medical insurance company and the organization providing these services.

Article 25. Taxation of Medical Facilities

Income earned by medical facilities through completion of compulsory health insurance program is not taxed.

Chapter 5. The Regulation of the Relations Between the Parties in the System of Health Insurance

Article 26. The Regulation of the Relations Between the Subjects of Health Insurance

The relations between the subjects of health insurance are regulated by this Law, by the legislation of the Russian Federation and other normative acts, and also by the terms of the contract concluded between the parties.

Any conflicts concerning health insurance should be examined in courts according to their competence and in the order set up by the legislation of the Russian Federation.

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Article 27. Penalties of the Parties in the System of Health Care

The insurant that refuses to pay insurance premiums for compulsory health insurance is officially liable to pay the fine equal to the corresponding insurance premium. The payment of the fine does not relieve the insurant of his duties under health insurance program.

According to the legislation of the Russian Federation and the terms of the contract medical facilities are responsible for the volume and quality of the services provided and are penalized for the refusal to provide the necessary services to the insured party. In case of the violation of the contract on behalf of the medical facility the health insurance company may partially or in full refuse to pay for the services provided.

The insurance company is legally and materially responsible to the insured part for the fulfillment of the contract. The specific amounts of compensation for damages is to be stated in the health insurance contract.

Insurance companies should pay for the services provided by medical facilities in the way and within the time period specified in their mutual agreement, but no longer than one month after the reception of the bill. The penalties for delays in payment are to be determined in the contract.

For a groundless refusal to sign a compulsory health insurance contract the insurance company may be deprived of its license.

Article 28. The Right of the Insurance Company to Demand the Compensation of Expenditures

The insurance company has the right to demand that legal entities or individuals responsible for damaging the insured individual's health should compensate its expenses for medical services, unless the damage was inflicted by the insurant.

Basic Provisions
of Ordinance of the Council of Ministers -
Government of the Russian Federation
"On Measures for Enforcing RF Law "On Amendments and
Additions to RSFSR Law "On Medical Insurance of
Citizens in the RSFSR" (Dated October 11, 1993, No. 1018)

The Council of Ministers hereby DECREES:

1. ***Executive authorities of the subjects of the RF shall, prior to November 1, 1993:***

   a) *appoint executive directors of territorial funds for compulsory medical insurance (TFCMI) and resolve all logistic issues related to the arrangement of their activities.*

   b) *approve territorial programs for compulsory medical insurance (CMI) built on the basic CMI programs.*

2. ***The Federal CMI Fund (FCMIF) shall:***[1]

   a) *in consultation with the Ministry of Health of the RF and the Ministry of Finance of the RF, prior to November 1, 1993, approve procedures for determining average per capita rates of financing the territorial CMI programs;*

   b) *in consultation with the Federal Service of Russia for Supervision over Insurance Activities, prior to November 1, 1993, approve standard CMI Rules and a format for a standard agreement between TFCMI and an insurance medical agency;*

   c) *in conjunction with the Ministry of Health of the RF, professional medical associations, TFCMI, prior to November 1, 1993, develop training programs for the CMI system and implementation of research studies in this area;*

   d) *in conjunction with the Ministry of Health of the RF, prior to November 15, 1993, submit proposals for improving reporting documentation within the CMI system;*

   e) *furnish to the Council of Ministers - Government of the Russian Federation of the RF, along with a draft republican budget for 1994, proposals related to procedures for calculating payments for CMI of unemployed citizens.*

3. *FCMIF, the Federal Service of Russia for Supervision over Insurance Activities, the Ministry of Health of the RF, and the Ministry of Finance of the RF, shall, prior to December 1, 1993, approve accounting procedures for CMI funds and medical institutions operating within the CMI system.*

4. ***The Ministry of health of the Russian Federation shall:***

   a) *develop, in preparing a 1994 budget, and submit to the Council of Ministers -Government of the Russian Federation proposals on*

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[1] CMI is equivalent to CHI in the text, FFMCI to FHIF, and TFCMCI to RHIF. The author.

procedures for financing medical institution which are not part of the system of the Ministry of Health of the RF as well as medical institutions of the federal level which are under the Ministry of health of the RF;

b) in consultation with the Ministry of Finance, FCMIF, prior to December 1, 1993, approve settlement procedures between health authorities and territorial CMI funds for provision of the medical care under CMI.

5. The Federal Service of Russia for Supervision over Insurance Activities, the Ministry of health of the RF and FCMIF shall, prior to November 1, 1993, submit for approval by the Council of Ministers - Government of the RF rules for licensing the activities of insurance medical agencies involved in CMI.

6. TO APPROVE attached:

a) Instructions on Procedures for Collecting and Accounting for Contributions to CMI;

b) standard CMI agreements for employed and unemployed citizens."

PD-ABP-266

TASK ORDER FOUR

FINAL REPORT

Annex 2 - Part 2

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February 28, 1995

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N. B. The information in this annex is in summary form. Extensive background documentation is available through IBTCI.

HEALTH CARE IN RUSSIA: POSSIBILITIES FOR CHANGE

The Russian public appears to be extraordinarily confused at this time about the emerging choices and their role in these choices beginning to confront the Russian health care consumer. Simply looking at the survey responses, one may come to the conclusion that the entire Russian public is schizophrenic - on the one hand they are distressed about the current state of health care in Russia and exhibit tendencies that can only be construed as pro-reform, but in the next instant they will appear to be perfectly satisfied with care that they have received and assert that Russia's problems are only temporary and changing the system would be a grave error.

This continual juxtaposition of seemingly incongruous statements and opinions is not however hinged on a mass imbalance in the Russian psyche. Instead, it demonstrates the delicate balance that must be achieved in the public's mind, in order to effectively persuade them that reform is both necessary and beneficial. It also proves just how vital the public education component of the privatization process will be in sweeping away the cobwebs of ignorance and infiltrating the dark corners of disillusion that already pervade public attitudes toward reform and privatization.

THE CURRENT ENVIRONMENT

The public continues to be quite negative when evaluating the direction of the country. Fully sixty-one percent (61%) of Russians assert that the nation is "off on the wrong track," while only twenty-two percent (22%) counter that things are headed in the right direction. The wrong track score has hovered around the 60% mark all year, so while in the United States this would be quite high, such negativity is nothing new for Russia. Respondents in the Far East region, less educated persons, older respondents and those with lower incomes exhibit the highest negativity about Russia.

There has been a marked increase in concern about national political leadership, with fully three-in-ten Russians asserting that this is the biggest problem facing their country. Almost half (47%) of college-educated respondents name this issue as the top problem, along with young men under the age of 45 (37%), respondents in rural areas (34%), and employed persons (34%), especially those in the private sector (38%). High prices (17%), crime (14%) and unemployment (11%) also receive double-digit mentions as the top issue in Russia.

It is interesting to note that when queried as to the number one problem facing them personally, respondents transfer concern immediately to high prices (40%), while unemployment remains about the same (10%) and health problems (10%) and housing (7%) surface as issues. Notably, it is older respondents who are driving concern over health problems, with 24% of those over the age of 65 and 21% of retired persons mentioning the issue. They also tend to live alone (16%) and have lower incomes (14%).

Of the three institutions tested among the public, the Ministry of Health is faring the best in their eyes. Although only 12% indicate that the MOH is doing an "excellent" or "good" job right now, 42% rate its performance as "satisfactory" and only 31% as "unsatisfactory." In comparison, 44% of Russians

indicate that the Duma is doing an "unsatisfactory" job and few Russian citizens know enough about the GKI to make an evaluation of its performance (43% are unsure or have no opinion).

Respondents are quite satisfied with their local polyclinics, as fully 60% indicate that they are satisfied and only 31% are not. Satisfaction in urban areas is seven points higher than in rural areas (62% to 55%), and is six points higher among women (62%) than men (56%). Older women, especially, tend to be quite satisfied with the polyclinics (65%), as are those who have used unpaid medical care in the last two years (62%), compared to just 50% of those who have not.

The public is rather unsure what their oblast health committee is doing (40%), while over one-third (36%) are currently satisfied and just 24% are dissatisfied. Rural respondents, younger people and those in the Southern Russia region are more knowledgeable and more satisfied with their Oblast health committee than their counterparts elsewhere.

USE OF HEALTH CARE

Most Russians evaluate themselves as being fairly healthy, with less than one-quarter (23%) saying that they are in poor health. However, among those over the age of 65 this climbs to fully 54%. It is especially high among older women, as forty-one percent (41%) of females over the age of 45 rate themselves as being in poor health, compared to just 29% of men in this same age bracket (although, men have a lower life expectancy than women). Thirty-five percent (35%) of low-income respondents indicate that they are in poor health, compared to just 15% of middle-income and 10% of high income respondents.

Eighty-two percent (82%) of Russia's citizens have received medical care, either personally or for a member of their family, for which they were not charged outright (what we will refer to as unpaid care). Rural respondents are slightly more likely than their urban counterparts to have received unpaid care (86% to 80%). The tendency to visit a medical facility increases with the education level of the respondent, so that college graduates are the most likely to have received care (85%) in the last two years.

Predictably, those over the age of 65 are the most likely group to have received unpaid care (86%), although this is only four points more than respondents under the age of 45. Respondents with children are five points more likely to have received unpaid care than those without children (84% to 79%).

The vast majority who received unpaid care did so at a polyclinic (71%), while two-in-ten (20%) sought care at the hospital. Just eight percent (8%) received a visit from the doctor, while one percent (1%) saw a midwife. Those who went to the hospital are much more likely to be from rural areas (28%) rather than urban areas (17%). Men over the age of 45 are the most likely to have been in the hospital (27%), and the tendency to have been in the hospital increases as respondents' education levels and income decline.

Eight percent (8%) of those who received unpaid care over the last two years had surgery (again, more likely to be older men or in rural areas), while nearly half (46%) received emergency care or treatment for such ailments as pneumonia (7%), cardiac care (6%), blood tests (8%), stomach/ulcers (6%), etc. The tendency to have received treatment for these ailments is more likely to come from older people, increasing to 65% of those over the age of 65 who sought medical care.

Only six percent (6%) had a general examination and another 6% sought pediatric care, while fully 17% sought relief for minor colds. These minor complaints were usually from younger respondents (44% of 18-34 year olds and 39% of 35-44 year olds) and those in urban areas (31%).

Another seven percent (7%) indicate that they did not pay for dental care, increasing especially in urban areas (10%) and among college graduates (12%).

Just fourteen percent (14%) of the public who received medical care for which they did not have to pay, did have to give their doctor or nurse some type of gift or cash payment. This practice appears to be much more common in large cities (16% of those in cities over 500,000 people). Younger respondents are also much more likely to indicate that they have had to engage in this practice, with 21% of 18-34 year olds, 18% of 35-44 year olds and 11% of 45-64 year olds saying this occurred (only 4% of seniors). The practice also increases with the income level of the respondent, increasing to 20% of those in the highest income bracket.

The vast majority of the respondents who received unpaid care are fairly satisfied with the care that they received. Forty-four percent (44%) rate the care as excellent or good, while 46% say it was fair and only eight percent (8%) evaluate the care as "poor." Younger women, college-educated respondents and those in large cities are the most likely to rate the care that they received as poor.

Less than one-quarter (22%) of the respondents indicate that they have received care, for which they have outright paid. Nearly half (46%) of this has been for dental care, although a myriad of other treatments were mentioned, such as cardiac care (5%), general examinations (8%), surgery (3%), neurological problems (5%) and ulcer/stomach ailments (4%). Again, nearly all "paid" procedures took place at polyclinics (69%), hospitals (10%) or in a doctor visit (8%). However, midwives appear to be paid quite frequently (8% of all paid treatments).

Quality of care does not appear to differ greatly between paid and unpaid treatments. Of those who paid for a medical procedure, 57% rate the care as excellent or good (slightly higher than unpaid), 27% as fair (lower), and twelve percent (12%) as poor (4 points higher).

Few respondents indicate that they have not sought care for themselves or a member of their family recently because of "concerns about the quality of the care, whereas in the past you probably would have sought care." Fifteen percent (15%) of the people respond positively to this query, not dropping below 8% with any key group.

Concern about quality appears to be the highest in the Far East region (22%) and in the largest cities with populations over 500,000 (17%). One should note that this concern is not out of ignorance or

due to concerns about costs, as those who say they have stayed away from treatment out of concern about quality are more likely to be well-educated and have higher incomes than those who have not. In fact, nearly one-quarter (23%) of college graduates have not sought care due to quality concerns (less than 12% of those with a high school education or below say the same). Similarly, eighteen percent (18%) of those in the highest income grouping have stayed away from receiving treatment due to these concerns (drops to 15% of middle and lower income respondents).

Concern also tends to decrease with age, so that just 8% of seniors have not sought care because of quality, but fully 17% of 35-44 year olds and 21% of those under the age of 35 respond positively to this inquiry. Parents with children at home also tend to be more concerned (18%) than those without children (13%).

VIEWS ON THE CURRENT STATE OF HEALTH CARE

A majority (55%) of Russian citizens indicate that they are not satisfied with health care in the country, with sixteen percent (16%) saying that they are "not at all satisfied." Conversely, twenty-nine percent (29%) state that they are satisfied with their health care, although only 9% say they are extremely satisfied. Another 12% have not used the health care system in quite awhile and do not feel free to pass judgement.

One should note that the views of the consumers very nearly match the views of health care providers in the country on this question. Fifty-five percent (55%) of doctors, nurses, bureaucrats and pharmacists also indicate that they are not satisfied with the current state of health care, while 45% indicate that they are satisfied (there was no option for lack of experience with the system, so satisfaction ratings are higher among providers than consumers who could opt out of a decision based on lack of knowledge).

However, in other areas, the providers appear to be much more negative than the recipients of care. Seventy-eight percent (78%) of health care providers indicate that the system is less secure than ten years ago. In addition, seventy-eight percent (78%) assert that the current health care system does not meet Russia's needs.

Of the consumers who indicated on this question that they are not satisfied with health care in Russia, were then asked an open-ended question as to the most important reason for their dissatisfaction. Fully one-quarter (25%) of the respondents cite a lack of medicine, especially important in the rural areas (41%) and among seniors (42%). Two-in-ten Russians identify rude and irresponsible behavior by doctors as their biggest problem with the system, which tends to be the focus of urban respondents (24%), especially those in the biggest cities (31%). Twelve percent (12%) name general incompetency on the part of doctors, something more likely to be noted among younger and higher income respondents. A myriad of other concerns also arise, such as outdated equipment (7%), long lines and waits for care (8%), a lack of specialists (3%), and high fees (5%).

One should note that when respondents are given a list of health care issues and asked to prioritize which one the government should be working on first, "keeping hospitals and polyclinics supplies with necessary equipment and drugs" moves to the forefront of concerns (39%). Concern over this aspect of the health care problem is being driven by respondents in rural areas of Russia, as nearly half (49%) cite supplies first. Reducing pollution in the environment arises as the next biggest issue that the public wants their leaders in Moscow to handle (16%). One-in-ten Russians want the government to work on training doctors and nurses in the most modern medical procedures, 5% indicate that keeping the pharmaceutical factories open should be the priority, while everything else receives minimal support. Another 22% of the public take a holistic approach that a combination of concerns should be focused on.

However, when voters are asked to focus on the biggest worry for them personally, money becomes the top concern. Three-in-ten Russians say that what worries them the most is the possibility that the "government will run out of money to fund the health care system and we will have to pay more than we can afford for treatment."

In fact, fully seventy percent (70%) of the Russian public note that they worry "a great deal" that they "might be required to pay" for their family's basic medical care. And an overwhelming, eight-one percent (81%) of the public indicate that they worry a great deal about not being able to pay for medical care if they or a family member "suffered from a catastrophic illness in the future." Concern about one's ability to pay for care especially in the current economic environment cuts across almost all geographic and demographic lines. Only high income respondents tend to be slightly less concerned and measure approximately 20 points less concern on both issues.

Long waits for medical care appear not to be as big a problem as in the past, with nearly half (49%) saying that they "never need to wait" to get a doctor's appointment, etc. The most that anyone describes having had to wait is one month or more, although only 5% have had this experience. Of those who have had to wait a week or more (13%), most are in the largest cities (22%) and rated the care that they received as poor (22%).

Waits for care once they have arrived at the facility are generally less than three hours, with 40% saying they have had to wait one hour or less, 27% stating that it was 1-2 hours, and only 7% indicating that they waited 3 hours or more. Another 13% say they have never had to wait and 11% have not used medical care.

Respondents were also queried about the availability of medicine over the last six months to a year. Forty-one percent (41%) indicate that the supply has gotten worse, compared to over 52% of health care providers. For both groups, those in rural areas report much more of a scarcity than their urban counterparts, as well as those in the Far East region. Three-in-ten Russians say that the supply of medicine has improved over the last six months to a year, while 17% say it is about the same.

Forty-two percent (42%) of the public says that the quality of medicine is about the same as a few years ago, while eighteen percent (18%) regard it as better and 10% as worse. Urban areas report worse quality than their rural counterparts. In addition, younger and more educated respondents are

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more likely to view the quality of medicine as improved.

Respondents also apparently are willing to buy items, such as cosmetics, at a pharmacy (36%), while just 16% would only buy these items where they do presently. The idea is more widely accepted in the Ural/Siberia region (47%) and in towns of 50 to 100,000 people (51%). Men and women under the age of 45 (41% each) are also more open to this idea than either men or women over the age of 45 (27% and 34%, respectively).

PUBLIC VIEWS OF INSURANCE -

Just over half (57%) of the Russian public has seen, read or heard something about the insurance law passed last year, an awareness level over 30 points lower than among health care providers in the country (88%). Awareness is over fifty percent (50%) in every region of the country, and is particularly high in the Far East area, where fully 83% of respondents have heard of the new law. Respondents in urban areas appear to be driving awareness of the new law, as 60% of these respondents have heard of it, compared to only 49% of those in rural areas.

The more educated also appear to be paying closer attention to the issue, with three-fourths (75%) of college graduates indicating that they heard of the insurance reform law, dropping to 63% of technical school graduates and down to 52% of high school graduates. Only 41% of those who less than a high school education have heard of the new law.

Similarly, higher income respondents are more likely to have heard of the law. Three-fourths (75%) of those in the highest income bracket and 64% of middle-income respondents know of the new law, as compared to less than half (48%) of those in the lowest income range. In addition, middle-age respondents tend to exhibit higher awareness levels than either young or old respondents. While over 60% of those between the ages of 35-64 indicate that they have seen, read or heard of the insurance law, awareness drops to 58% of those under the age of 35 and to just 38% of those over the age of 65.

Respondents that are categorized as dissatisfied and more open to reform also appear to be paying closer attention to the issue, with 61% of this group indicating that they have heard of the new law. Awareness drops to 47% among those who are in the satisfied/reform resistant group.

Of those respondents who have seen, read or heard about the new law, sixty-one percent (61%) are also aware of the voluntary insurance provisions of the new law "that allow for greater medical coverage through voluntary contributions in addition to the mandatory basic coverage." Again, awareness is basically determined by education levels, with college-educated respondents much more likely to be aware of this aspect of the new law (71%). It drops down to just 47% of those without a high school degree who were aware of the law, also knowing about the voluntary provisions within it.

Older voters also tend to be less knowledgeable about these provisions than their younger

counterparts (only 50% of those over the age of 55 know about this aspect of the law). Young women under the age of 45 appear to be the best-informed about the new insurance law, as fully 67% exhibit awareness of the voluntary provisions.

In addition, dissatisfied respondents are more likely to be aware of the provisions in the law, as 61% say that they have seen, read or heard about this aspect of it. Awareness drops 4 points among those who are satisfied.

Health care consumers are fairly positive in their assessment of the new law's impact on health care in Russia. Thirty-eight percent (38%) of the respondents who are aware of the law state that it will improve the health care they receive, although only 6% feel that way strongly. This compares to 29% of health care providers who believe the new law will have a positive impact on what they do. Just one-in-ten Russians assert that the changes in the law will make the health care they receive worse (compared to 33% of providers who say it will adversely affect their work). Approximately one-quarter (26%) of the public indicates that the new law will make no difference to their health care, while another 26% are unsure of the effect it will have.

Rural respondents are much more positive in their predictions of the law's impact, as 44% foresee it improving their health care while only 36% of urban respondents say the same. Those in the Southern Russia (40%) and the Far East regions (39%) also tend to be more positive than their counterparts elsewhere.

Age is a strong determinant of attitudes on this issue, with positive assessments more common among younger people. Nearly half (48%) of the respondents under the age of 45 believe that the new law will improve the medical care that they receive, dropping to approximately 40% of middle-age respondents and to just 26% of those over the age of 55.

There is a slight gender gap on this issue, with men being more positive about the new law than their female counterparts. Forty-one percent (41%) of male respondents indicate that the insurance law will improve the health care that they receive, while optimism among women is five points lower (36%). This is apparent among younger respondents as well, with 49% of men under the age of 45 saying that the law will improve care but only 42% of women in this same age group echoing this feeling.

Other key groups that tend to be more positive in their view of the law and its impact on the system are high income respondents (53% improve), those with children (44%), graduates of technical schools (45%), respondents who believe business running health care would improve the system (52%), and those who had predicted the system would be better in the next ten years anyway (61%).

PUBLIC EDUCATION/PREVENTION CAMPAIGNS

Two-thirds (66%) of the public have seen, read or heard something about the government's public education campaigns "about public health issues that promote a healthier lifestyle, such as the hazards

of cigarette smoking, excessive alcohol drinking..." Awareness of this effort is above 60% in every region of the country, particularly in Southern Russia where 71% of the respondents know of this government program.

Younger respondents are generally more aware of these government efforts than older people. Fully seventy-one percent (71%) of those under the age of 35 indicate that they have seen, read or heard something about these efforts. Awareness drops to approximately 66% of 35-64 year olds and 58% of those over the age of 65. Awareness also increases with education level, so that fully 71% of college graduates have heard about these campaigns. Income, however, is not a major determinant of attitudes on this issue.

Respondents with children at home (70%), those who are classified as dissatisfied and open to reform (69%) , and those who received medical care for themselves or their family in the last two years (67%). Notably, three-fourths of those who had heard of the government insurance law are also aware of their efforts on public health education.

Unfortunately, a high level of awareness does not translate into effectiveness. Less than one-quarter (24%) of the respondents who are aware of the government's efforts indicate that the program has caused them to "change any habits or do anything differently." The campaign has been more effective with younger respondents, as 30% of 18-34 year olds assert that they have made changes based on the information they received through the public health campaigns. This drops to approximately one-quarter (25%) of middle-age respondents who have made changes because of the program and only 16% of seniors who modified their behavior as a result of this. Young women under the age of 45 have been especially prone to change (30%), five points more than men in this age group. There are little to no gender or income-based differences in attitudes. However, the programs do appear to be more effective among rural respondents (27%) than urban residents (23%).

The public is already fairly well informed on the benefits of preventive medicine, as seventy-one percent (71%) agree with the idea that "it is better to prevent illness by doing things such as seeing a doctor once a year for a physical examination, exercising and eating right." A mere eleven percent (11%) are more likely to agree with the view that "you only really need to see a doctor when you are sick. Besides exercise and changing your habits are more bother than it is worth and will not help that much anyway." Thirteen percent (13%) state that both views carry about equal weight.

The only groups who resist the benefits of prevention are almost all older people, as 18% of 55-64 year olds and 14% of those over the age of 65 agree with the view that it is more of a bother than a help. This sentiment also tends to be stronger among older men (16%) than older women (13%). Resistance also tends to come from less educated voters (who generally are older), with 16% of those with less than a high school education and 13% of those with a high school degree are more likely to think that prevention is not worthwhile.

Notably, respondents with children are ten points more likely to agree with the pro-prevention view (76%) than their counterparts who do not have children at home (66%). High income and white collar workers also are much more likely to agree with the views supporting prevention.

On a similar note, eighty percent (80%) of those who have children in the home indicate that they have received all their necessary vaccinations, while 16% indicate that they have only received some of them and just 4% report them not receiving any. Although this may be a case where respondents are prone to answer in a "politically correct" fashion, awareness that this is the right thing to do at least is evidenced by their responses. The only region where the vaccination rate is slightly lower is the Ural/Siberia region, where just 69% report their children have had all their vaccinations.

THE FUTURE OF HEALTH CARE

With all the worries expressed about the current state of health care, it is somewhat surprising that Russians are as optimistic as they are when asked to predict the future of the system. The public is more likely to speculate that health care in the next ten years will get better (32%) than either deteriorate (21%) or stay the same (21%). However, over one-quarter (26%) are unsure what the situation will be ten years from now.

Russia's youth tend to be driving the optimistic predictions for Russia's health care system. The view that things will get better increases as age declines, so that fully 41% of 18-34 year olds make this assertion, dropping to just 26% of those over the age of 65. Optimism also tends to increase with income of the respondent, with just 27% of low income respondents indicating that health care will improve, while 34% of medium income and 40% of high income respondents predict things will improve.

Notably, a majority of respondents tend to view the problems of the health care system as temporary rather than inherent in the system. Fifty-four percent (54%) of the public agrees with the statement: "The health care system we have in Russia is an inherently good system and the current problems are only temporary," while 35% disagree.

This view tends to be more dominant in rural areas of the country (60%) than with urban residents (52%). It is above 50% in every region of the country and the view is fairly widespread with little deviations based on gender, age or income. Education level plays a minor role, with college graduates being slightly less likely to agree (49%) with the idea that the problems are only temporary.

Among respondents who are in the satisfied/resistant to reform classification, fully seventy-four percent (74%) agree with the idea that Russia's health care problems are temporary and just 15% disagree. However, among those who were classified as being more open to reform, support for this view drops 24 points to 50%, while fully 41% disagree with this idea. Yet another indication that this group could be persuaded to accept major reforms.

VALUE CHOICES

Quality

Respondents were also asked to make certain choices based on possible reforms to the health care system. A majority (55%) of Russians indicate that "keeping medical care free to all Russians" should take precedence over "making sure the quality of health care you and your family receive is the best it can be even if it means paying something" (40%).

Again, age is the key determinant of attitudes on this issue, as one can see in the following diagram:

AGE	FREE CARE	QUALITY CARE
18-34 years	38%	57%
35-44 years	40%	54%
45-54 years	57%	38%
55-64 years	71%	22%
65 and over	82%	13%

This is an extremely dramatic rise in concern over cost and a desire for the status quo among older voters. It is slightly higher among older women over the age of 45 (73% for free care) than older men (67% for free care).

More educated voters are also much more likely to demand quality care even if it comes at some cost to them personally. Half (50%) of graduates from technical schools and 55% of college graduates indicate that quality care is more desirable than free care (45% and 39%, respectively). This contrasts sharply against the attitudes of less educated respondents, among whom only 17% put a premium on quality while fully 80% desire free care. Obviously, income also plays a role in attitudes on this issue, with those more able to pay for care also more willing to pay.

One should note that the Far East is the only region where voters are split on this issue, as forty-five percent (45%) choose free care, and an equal number prefer quality at a price.

However, when asked whether they prefer a system where some types of procedures are restricted from a basic care package if the quality of basic care improves (59%) or a system where anyone can receive any type of treatment but quality stays the same (36%), the public is willing to make some sacrifices. Thus, one can reason, that some sort of basic care package must remain "free" to the Russian public to appease their concerns about being able to afford basic care for themselves and their families. They are used to certain restrictions being placed on their choices, but are concerned in these precarious economic times, that they will not be able to afford anything.

Once again, age is the major determinant of choices on the issue. Approximately seventy-three percent (73%) of respondents under the age of 45 are willing to endure restrictions on care in order

to improve the quality, dropping to 65% of 45-54 year olds, 43% of 55-64 year olds and just 33% of seniors. In fact, respondents over the age of 55 are more likely to want no restrictions at all or care (52% of 55-64 year olds and 61% of seniors) than would accept limitations for improved quality.

As on the first question, more educated people tend to place a premium on improving the quality of health care. Over 70% of technical school and college graduates would accept restrictions on types of care that are covered in order to improve quality, dropping to 62% of high school graduates and just 37% of those without a high school education.

Individuals employed in the private sector (77% restrictions), high income (78%), those with children (69%), men (64%), and urban respondents (61%) also tend to place more value on raising the quality of care even if this means restricting their choices.

Cost

A majority of the Russian public is against individuals paying for health care, although there is about 40% of the population which currently prefers reform options or believes they are equally as good as the current system. Fifty-three percent (53%) of the public agree with the view that "people should never have to pay for medical care as they cannot afford basic care and should only have to pay for 'extra comforts," such as private rooms or very expensive treatment methods." Twenty-one percent (21%) are more inclined to agree with the idea that "patients paying for medical services is the only way to create competition among doctors and force them to provide better quality care while still keeping fees at reasonable rates." Another 22% believe both views have equal merit.

Predictably, older Russians tend to be much more conservative on this issue and much more concerned about retaining "free" care than their younger counterparts. Fully, sixty-seven percent (67%) of those over the age of 65 and 64% of those between the ages of 55 and 64 believe that people should never have to pay for care. Support for this view drops to 55% of 45-54 year olds, 48% of 35-44 year olds and to just 40% of those under the age of 35. Among the latter group, 29% actually agree with the idea that paying for services is the only thing that will foster competition and bring up the level of quality - one of the highest support levels of any key group.

Less educated respondents are driving the view that health care should continue to be free to patients, as two-thirds (66%) of those with less than a high school education opt for this view. Support drops over 15 points among respondents with a high school degree or more (approximately 48%).

Notably, there is virtually no difference in attitudes of urban and rural respondents. However Russians in the Central/Northern region tend to be more supportive of free care (58%) than those in the Southern (52%), Ural/Siberia (47%) or Far East (51%) regions.

Women are six points more likely than men to think that care should continue to be free and provided by the government (55% and 49%, respectively). This gap is evident among both older and younger women.

Respondents who are employed in a private sector company (36% patients pay) or one that is in transition from public to private (31%), have children (25%) or are in the dissatisfied classification (22%) are the most open to the concept that patients paying for care is the only way to foster competition and thereby improve quality.

A plurality (46%) of the Russian public indicate that they would still go to their local polyclinic even if cost was not a consideration, although 22% indicate that they would go to a local private doctor. Only ten percent (10%) are concerned about portability, in that they would go to a polyclinic in another city, with most of these responses coming from rural areas (18%). Likewise, eight percent (8%) of the public would go to a private doctor in another city, driven by rural respondents (12%).

Going to a local polyclinic is the chief preference for respondents in every region of the country, never deviating more than two points from the national average. As was pointed out earlier, rural respondents are more likely to choose a polyclinic in another city (18%) so support for their local clinic is somewhat lower (42%) than with urban residents (48%). Acceptance of private doctors appears to be higher in the Far East region (36% for local or one in another city), Ural/Siberia (31%) and Central/Northern Russia (31%). Willingness to go to a private doctor if cost was not a consideration drops to 24% in the Southern Russia region. Overall, acceptance of private doctors is 8 points higher in urban areas than in rural areas (32% and 24%, respectively).

Age and education play important roles in determining respondents' acceptance of private doctors. Willingness to visit a private doctor drops almost twenty points from the youngest respondents (35%) to the oldest (16%). Likewise, college graduates are 16 points more likely to say that they would visit a private doctor if cost were not a factor than the least educated respondents.

Notably, even though cost was explained <u>not</u> to be a factor in their decision, income still is decisive to their decision. Willingness to go to a private doctor is 17 points higher among high income respondents than among those in the lowest income bracket. One should note that these individuals generally tend to be older, retired person on pensions and age may be the leading factor in the decision - not ability to pay.

Among those in the dissatisfied group, only 39% would stick with their local polyclinic if cost was not a factor, while 35% would choose a private doctor and 12% would go to a clinic in a nearby city. The satisfied/reform resistant group, however, by definition would tend to be happy with their local polyclinic (66% choose it), with only two-in-ten opting for a private doctor and 2% wanting to go to a clinic elsewhere.

Respondents were also queried as to what specific procedures or treatments that they would be willing to pay extra to receive if they were excluded from a government basic care package. The following diagram illustrates the results:

PROCEDURE	WILLING	NOT WILLING
Psychiatric care/therapy	31%	58%
Contraceptives/family planning	35%	48%
Alcohol abuse treatment	37%	49%
Preventative examinations	36%	57%
Medicine for children	45%	49%
Eyeglasses/optometric exam	45%	46%

As one can clearly see, there is great resistance to having to pay for basically anything. However, what this means might be somewhat unclear as the question may have been interpreted to mean different things. For example, one person might think that a program is vital and be objecting to the government not paying for it, as in the case of medicine for children, while another person might simply be saying that if the care cost something they personally would not seek that care and pay extra for it, as in alcohol abuse treatment.

These considerations aside, there is only a clear majority who would not pay extra for two items: psychiatric care and preventative examinations. This echoes the providers' sentiments on this issue as 97% consider it to be the government's responsibility to pay for psychiatric care and 70% say they should pay for preventative examinations. However, only 35% of the consumers say that they are willing to pick up the tab for contraceptives and family planning information, while 66% of the providers say the patients should bear this cost. Likewise, just 37% of Russians are willing to pay for alcohol abuse treatment, while 60% of the health care providers believe the consumers should pay for it.

Those who are willing to pay for most of these procedures tend to be high income, under the age of 45, college-educated and work for a private sector company. Men are usually a few points more likely to indicate that they would pay extra for a service than their female counterparts.

Type of Facility

In the next portion of the interview, health care consumers were moved into making choices based on possible reforms to the Russian health care system. First, respondents were told about "health trusts" as follows: "There has been some discussion about creating some hospitals and polyclinics that are not run by the government, but are run by 'Health trusts.' This means that while the government still maintains certain standards for things such as safety, the administration of the hospital is in the hands of a church, charity, union or some other private group that does not make a profit off of the enterprise."

A majority (55%) of Russians indicate that they would be willing to go to these type of hospitals or polyclinics run by health trusts, with 17% strongly willing. Only one-third (33%) are opposed to visiting this type of facility, and just 12% are strongly not willing.

Geographically, rural respondents are much more open to the idea of seeing a doctor at a non-profit institution, with 63% of these residents willing to visit as health trust facility (only 25% not willing). Openness drops to 52% of urban residents, while 35% are opposed to such an idea. Southern Russia respondents are quite open to this new type of facility (62% willing), compared to just 54% of those in Central/North Russia, 52% of those in the Far East and just 48% of respondents in the Ural/Siberia region.

There is only a slight gender gap on this issue, as 57% of men are willing to visit a facility run by a health trust while 53% of female respondents say the same. Older women are the most resistant to the idea, as just half (50%) indicate they would be willing to visit such an institution while 35% are not.

Age continues to play a major role in respondents' health care attitudes, with openness to visiting a health trust facility decreasing as age increases. While fifty-eight percent (58%) of the youngest group of respondents are open to seeing a physician at a non-profit, non-government facility, less than half (49%) of the oldest respondents would do the same.

In examining the target groups, satisfied respondents are the most resistant to these new facilities, with only 44% willing to visit one and fully 40% saying that they would not. Among the group characterized as dissatisfied with the current system, fully 58% are open to this new type of facility, while less than one-third are resistant to the change (32%).

Unemployed respondents (63%), those with children in the home (57%) and high income respondents (59%) are also more likely to indicate a willingness to visit these new facilities.

Respondents were then moved into deciding their actions if the facility "was owned by a private group, such as a groups of doctors that also work there, but the group might make a profit if they do well." In this case, just as many people are willing to visit such a facility (55%) as are willing to visit a non-profit facility. Therefore, this added facet does not add or detract from the marketability of a private institution.

The addition of the "for-profit" clause into the hypothesis does have an interesting effect on some key groups in Russia. Geographically, the concept detracts from the facility's marketability among respondents in the rural areas (54%/-9 points), particularly among those in Southern Russia (56%/-6). However, this injection of capitalism slightly enhances support among urban residents (55%/+3), those in the Far east region (60%/+8) and notably, in the Ural/Siberia area (57%/+9). Openness to these reformed institutions does not shift very much at all among those in Central/Northern Russia (-2).

The addition of the for-profit concept has the biggest negative impact on older people, although it turns out to be a plus among young people as one can see in the following diagram:

AGE	WILLING/ FOR-PROFIT	CHANGE FROM NON-PROFIT
18-34 years	67%	+9
35-44 years	59%	+3
45-54 years	58%	+2
55-64 years	45%	-7
65 and over	39%	-10

The impact of adding the for-profit concept also tends to be more of a plus among more educated respondents. Fully 67% of college graduates and 60% of technical school graduates would visit a doctor at a private, for-profit facility, a net gain of 9 and 7 points, respectively. Conversely, high school graduates and those with less than a high school education are less favorable to the idea if the facility could make a profit (-4 and -9, respectively).

The idea does have some unusual results among the target groups - adversely affecting the dissatisfied group (-2) and positively affecting the satisfied group (+5).

Of those who would resist going to a private, for-profit hospital or clinic, 36% indicate that the main reason they would not go is because they do not have the money. This tends to be by far the most important reason to rural respondents (56%), those over the age of 55 (45%), older women (45%), those with less than a high school education (50%) and those who are in the dissatisfied group (41%).

Thirty-one percent (31%) say they would not trust the specialists at such a facility, which is more of a concern to urban and younger respondents. Thirteen percent (13%) are concerned about the lack of government control on these facilities, especially respondents under the age of 35 (21%) and residents of the Far East region (17%). Just eight percent (8%) of those who would not go to a private, for-profit facility cite concerns about quality, mostly young men (13%) and less educated people (11%).

Respondents were then asked to choose between two opposing points of view about privatization and its effect on the Russian health care system. just over half (52%) of the respondents take a negative view of the situation and agree with the view that "allowing individuals and businesses to run the health care system will only make health care unaffordable for most Russians while letting these people get rich off our misery."

Just twenty-three percent (23%) of the public takes a positive view of privatization, arguing that "allowing individuals and businesses to run Russia's hospitals and pharmaceutical companies will make hospitals be more responsive to their patients' needs and eliminate the widespread inefficiencies of the state-run system through healthy competition." Another 19% believe that both views have equal merit, while 7% are unsure.

The view that private ownership of the health care system will foster competition and improve the system as a whole is more likely to be held by groups that have evidenced openness to reform throughout the data: 18-34 year olds (32% improve/40% make unaffordable), college graduates (35%/43%), private sector employees (40%/35%), high income respondents (40%/36%), dissatisfied respondents (27%/49%).

Geographically, there is substantially more support for a private health care system in the Far East region of the country (36%/41%) than in other areas. The Southern Russia and Central/Northern regions tend to be weakest areas, as fully 51% and 56%, respectively, believe that businesses running the health care system would make health care unaffordable for most Russians.

There is also substantial resistance predictably among the oldest respondents (65% unaffordable) and low income Russians (58%).

POSSIBILITIES FOR REFORM

Russian health care consumers were segmented into categories based upon their opinion of the health care system in general and their confidence in their doctors to meet their needs. Working on the assumption that those who are the most dissatisfied with the present system may be willing to undergo some type of change and be more open to reform, these groups fall into the following categories:

Satisfied/Reform resistant: 11%

- Central/Northern Russia
- Urban, although not in the largest cities
- 65 years of age and over
- Women over age of 45
- Retired
- Resistance increases as education level decreases
- Resistance increases as income decreases
- Place a premium on free medical care

Dissatisfied/More Open to Reform: 46%

- Ural/Siberia or Far East regions
- Towns with less than 10,000 people
- 18-34 year olds
- Women under the age of 45
- Have children
- College or technical school education
- "White collar" worker
- Think health care system problems are inherent, not temporary
- Used unpaid and paid medical care in the past two years

Neutral: 2%

Other/mixed: 41%

This hypothesis bears up when one examines the responses of the various groups to the tests on willingness to go to a non-profit facility or a for-profit facility. Of those who are satisfied with their health care, less than half (44%) say that they would go to a clinic or hospital run by a health trust that was non-profit. However, among those categorized as dissatisfied, a majority (58%) would be willing to visit such a facility - an increase of 14 points. Likewise, with a for-profit, private facility, only 49% of satisfied respondents say that they would go to such a facility, while 56% of dissatisfied

respondents indicate that they would.

Clearly, there are still fears to be overcome even with the group that is more open to change but there are promising signs throughout the data with this group on reform issues. For example, while 60% of the satisfied/reform resistant group indicate that individuals and businesses running health care facilities and the pharmaceutical industry would make health care unaffordable to most Russians, less than half (49%) of the dissatisfied respondents agree with this assessment of privatization and 27% assert that it would improve things. Those in the dissatisfied group are 24 points less likely than the satisfied group to believe that the problems in the Russian health care system are only temporary (50% to 74%). They are also less likely to put a premium on free care for all Russians and more willing to accept restrictions on care in return for better basic medical care.

However, one must be extremely careful in the rhetoric employed to rally support for the privatization process. When described a situation that is basically the privatization process (such as the question above), one sees that the dissatisfied group is quite open to the benefits of such a process. However, the term "privatization," per se, conjures up negative images for this group. While thirty-nine percent (39%) of the satisfied group assert that "privatization is always a bad thing," agreement with this statement jumps up to 47% with those in the dissatisfied group. This is mostly being driven by those in the Ural/Siberia area who are much more negative about both health care and privatization.

"PUSH" ISSUES

A number of statements regarding health care were tested in the last portion of the interview to examine public attitudes on a variety of fronts. The following chart illustrates the findings:

ISSUE	AGREE	DISAGREE
Western pharmaceutical companies are exploitative and should be barred	42%	45%
Russian system must be universal	58%	33%
I am better able than doctors to care for myself	23%	70%
Outdated equipment must be replaced	94%	2%
Privatization always a bad thing	45%	22%
Russian doctors better than Western doctors, because did not have modern drugs and expensive equipment	59%	20%

Clearly, the strongest agreement comes on the issue of replacing old medical equipment in the facilities, as 94% indicate this should be done. Remember, this is the public's top health care issues that they feel the government should work on (question 34).

There is quite a bit of mixed emotions over the issue of Western pharmaceutical companies being allowed into the Russian market. The idea that the Western companies are merely taking a situation ripe for exploitation and making money out of other peoples' misery tends to be the prevailing feeling among older men (49%), blue collar workers (47%), low income respondents (48%) and those who think the health care system is going to deteriorate (48%).

Views as to whether health care in Russia must be universal is almost solely based on the age of the respondent. Those under the age of 35 are actually more likely to disagree with the concept of universality (43% agree/47% disagree), while support for the idea increases as respondents' age increases. Therefore, fully 64% of 45-54 year olds, 71% of 55-64 year olds and 75% of seniors support universality of health care.

The most important finding, however, is the fact that forty-five percent (45%) of the public agrees

with the concept that privatization is always a bad thing. This is the predominant view in the largest cities with populations of over half a million (52%) and the Ural/Siberia region (51%), with 45-54 year olds (54%), blue collar workers (50%) and those who predict the health care system will get worse in the next ten years (53%). As was mentioned earlier, there is also a substantial block of those dissatisfied and more open to reform who reject privatization per se (47%).

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EXECUTIVE SUMMARY

Amidst the blizzard of policy papers descending on Moscow, "Healthy Russia 2000" is unique. Reform of the health-care system in Russia is already underway, but with wide regional and sectoral differences in the progress made to date. Accordingly, any policy discussions and recommendations can only be taken as part of an evolving, ongoing process. No policy "prescriptions," no snapshot of public opinion and no econometric model are fixed references, but only way stations along the process of health-care reform. In effect, therefore, this is a working paper on which work has already begun, and which will necessarily continue while the paper's recommendations for future implementation are studied and launched.

In Section I, "Healthy Russia 2000" sets forth a vision of the future of Russian health care. Today, there exists the possibility of achieving (a) meaningful universal access to (b) enhanced, efficiently-provided, cost-effective health care through (c) increased consumer choice and competition among health-care providers leading to (d) better health and greater satisfaction for the people of Russia. Emphasis will be placed on all four components of health care: prevention, early detection of disease, treatment and rehabilitation. Some aspects of health care (e.g., pharmaceutical manufacturing, distribution and retailing) can be privatized entirely. Other aspects, such as hospitals and polyclinics, will have more diverse possibilities, including continued government ownership, transfer to local-government control, management by not-for-profit organizations or outright privatization.

Section II describes Russia's current state of health, which, in short, is not good. Compared to OECD countries, Russians have shorter life expectancies; higher illness and mortality rates among working age persons; higher infant mortality rates; and a general weakening of the population's immune system because of environmental pollution, alcohol abuse and allergies among youth. The birth rate has decreased, the general mortality rate has increased, and the population is aging. The young, women and the elderly are particularly vulnerable, and men have the lowest life expectancy in any European country.

In Section III, "Healthy Russia 2000" examines the current state of the health-care system, especially available resources, in light of the health problems previously described. Significantly, the causes of many of Russia's health-care problems are manifestations of the overall difficulty of the transition away from prior structures and practices. Institutional resources, such as hospital facilities, are in relative over-supply but their physical condition is poor. The numbers of physicians and nurses are high, but their talents are not well utilized (often being spent on menial, non-medical tasks), and their pay and morale are low. Shortages of medical equipment are serious, aggravated by shortages of funding to purchase new, higher-quality equipment. The supply of pharmaceuticals is well below necessary levels. Plants are obsolete, production expertise for many drugs is lacking, and product ranges are outdated. The distribution of pharmaceuticals is one of the most serious problems in the entire health-care system, and will need significant restructuring, as will retailing. Health care has been historically underfunded, and national budget constraints have only grown worse. The Compulsory Medical Insurance law ("CMI") is in the early stages of implementation, and private payments are still a small percentage of the total expenditures for health care. As a result, real expenditures for health care are falling. Thus, the present system suffers from insufficient public funding, and yet also fails to attract private resources in sufficient qualities to meet aggregate needs. Brief analyses of the Dutch, German, British, Swedish and American health-care systems are provided to allow readers and decision makers to compare the existing Russian system to possible alternatives.

Section IV describes the results of the first systematic effort in Russia at consumer and provider polling on health care. Opinion is widely divided on the adequacy of existing health care and the need for reform. Younger, better-educated people tend to be more dissatisfied with the present system, and more ready to pay for increased care, compared to older, less-well-educated Russians who tend to prefer the system as it is. Wide regional variations also exist. Providers seem quite aware of the possibility of insurance, but consumers are far less informed. Despite existing public-information campaigns intended to improve lifestyles and thus health, very little real change in behavior has occurred. Nonetheless most Russians are optimistic about the future of health care, and there is a large minority supportive of major reforms in the system.

Section V describes a new approach to Russian health care, stressing that increased efficiency and competition can allocate scarce resources more effectively, especially since total resources available for health care are not likely to grow to any extent in the near future. Preventive medicine and increased consumer choice should be stressed. The pharmaceutical manufacturing, distribution and retailing industry should be privatized, and new local-government, not-for-profit and for-profit hospitals and polyclinics should be established. The CMI system must be made to work better, and sources of private financing need to be thoroughly explored.

Section VI proposes concrete steps to implement the new approach, some of which are already underway. Additional steps can be undertaken immediately, and some others will have to await the outcome of the general debate on health care expected in the near future. Substantial new laws and regulations will be needed to shape the new private and local-government institutions that will be created, and prevent the creation of new monopolies. Financing remains difficult, but steps must be taken to preserve meaningful access to universal care. Increasing workforce training and maintaining the quality of care are critical. Major work is needed to reshape the pharmaceutical industry, especially distribution. More effective public-education campaigns, for both consumers and providers, are essential to the reform program's success. Finally, a Presidential Commission will create stronger public support for this major undertaking.

SECTION I

A VISION OF THE FUTURE OF RUSSIAN HEALTH CARE

The people of Russia desire -- and deserve -- a health-care system equal in quality to that of the other industrialized democracies, and consistent with the World Health Organization's goal of "Health for All by the Year 2000." For too long, the Russian people have been prevented from attaining the goal of a healthy Russia because of policies designed to achieve ideological objectives which the people are now rejecting. Scarce resources were diverted, wasted and misallocated, and the health of the Russian people was impaired. Government bureaucrats made all of the key decisions about health-care, rather than the citizens themselves. As a result, health-care for Russians is in jeopardy. Today, however, there is a new opportunity to turn the system around that must be seized.

Today, there exists the possibility of achieving:

- meaningful universal access to
- enhanced, efficiently-provided, cost-effective health care through
- increased consumer choice and competition among health-care providers, leading to
- better health and greater satisfaction for the people of Russia.

This possibility, which will be accomplished through a major reorganization of the health-care sector, represents a critical priority for the government of Russia. Without doubt, it will be a monumental undertaking, and will have to take political realities into account, but it should nonetheless be embraced by all of those concerned about a healthy Russia.

Universal access to health-care, although theoretically available in the country, has too often been inadequately realized because of favoritism, inequality in the distribution of personnel and resources, and inefficiency. Chronic underfunding -- because health was actually a low budget priority in the Soviet Union -- resulted in poor performance. "Universal access" became yet another political slogan masking the harsh reality of scarcity and rationing. A "Healthy Russia 2000" will make universal access a fact rather than simply rhetoric by empowering the Russian people to make their own decisions about health-care, and by providing adequate incentives to providers and other

suppliers in the health sector. There is already a generous supply of trained medical manpower which can and should be put to better and more productive uses.

Enhanced, efficiently-provided, cost-effective health-care is central to the new system. Allowing increased control and decision making by individual consumers, providers, and payor organizations over virtually all aspects of health-care, from hospitals to pharmaceutical distribution and retailing, will increase efficiency and cost-effectiveness almost immediately, and it will enhance the actual provision of health-care shortly thereafter as new and improved procedures, medications and facilities come into general use. In the four broad areas of prevention, early detection of disease, treatment, and rehabilitation, "Healthy Russia 2000" will ensure better services, drugs and medical products for the Russian people.

Increased consumer choice and competition among providers is fundamental to restructuring Russia's health-care system. By providing the people with options, thereby increasing competition among the providers, together with increasing the incentives for providers to be more responsive, "Healthy Russia 2000," through a strong partnership between government and the private sector, will make available the benefits of market forces. Campaigns to increase public awareness and understanding of the new system will help ensure that adequate information is available both to health-care consumers and providers. High-quality goods and services will be available more consistently with the people's actual requirements.

Better health and consumer satisfaction must be the ultimate goal of any reform in Russian health-care. Opening and reorganizing the financial, legal and all other aspects of the health-care system will be done with a clear vision that it is the people themselves who must benefit from the extensive changes that will be required, especially for the elderly, women, children, and other target groups. "Healthy Russia 2000" is not a plan for the privileged and the powerful, but rather one intended to benefit Russians throughout all regions of the country and throughout all segments of society.

In the field of **preventive medicine,** Russia lags far behind most industrial democracies. Yet prevention is now attracting more and more attention in those countries, both because of its overall contribution to individual health, and because of the important impact it has on holding health costs down. It is far more efficient and cost-effective to prevent medical problems than to cure them after they begin. Thus, for example, the Russian environment and dietary habits must be improved, workplaces must be made safer, and the excess consumption of alcohol and tobacco, and the use of illicit narcotics, must be curtailed for a "Healthy Russia 2000." These steps alone would substantially increase both the personal health and productivity of many members of the Russian work force and their families.

The **early detection of illness** can likewise have a powerful impact on individual well-being and cost containment. Curing illness before it becomes clinically advanced is better for the patients and their families, reduces the adverse impact on the economy from lost productivity, and is less costly overall. This is especially true for children, where early and periodic screening and vaccinations produce tremendous human and economic benefits. Because Russian procedures in the past have been oriented toward hospital treatment, much will need to change. Here, competition among physicians, polyclinics and other providers should be quite important in moving toward an emphasis on the early detection of illness. Public health interventions and policy will also be important.

Treatment obviously remains central to achieving the goal of a "Healthy Russia 2000." Making hospitals more efficient means that scarce resources can be used to bring better care to a larger proportion of the population. Competition, through vesting hospital ownership in private companies, non-governmental organizations, or municipalities; privatizing polyclinics; and permitting the private manufacture, distribution and retailing of pharmaceuticals and medical equipment can be an important factor in bringing about the needed changes. Increased efficiency and cost-effectiveness in the provision of care can help reduce costs and benefit both providers and consumers.

Rehabilitation remains an important part of health-care, but it also must change. New opportunities will emerge as a result of the expected de-emphasis of in-hospital treatment, as the discipline of new

payment mechanisms reduces the length of hospital stays, once again enhancing the welfare of the patients and their families, while simultaneously reducing the costs of health-care.

No one doubts that the process of achieving a "Healthy Russia 2000" will be difficult. The state of the overall national economy will be an important factor. There are substantial differences among Russia's regions in the provision and quality of health-care, in the availability of resources (financial, technological, personnel and institutional), and in methods of financing. Substantial underfunding exists throughout the country, especially as government budgets fall in a difficult macroeconomic environment. New insurance plans are only partially operational, and their efficacy and long-term viability still too early to predict.

New legal and regulatory structures must be conceived and implemented successfully, involving new modes of ownership, commercial transactions and taxation. Standards for the production quality of medical goods and provision of services must be sustained and improved. Providers of foreign economic cooperation must believe that serious reform is possible and worth the commitment of substantial external resources. Potential foreign investors must also be convinced of the viability of trade and investment. Public confidence and awareness about the benefits and importance of the restructuring must be stimulated and sustained. Health-care providers, manufacturers and distributors must become enthusiastic advocates for change. There must be a strong coalition of support in the Duma.

"Healthy Russia 2000" fully understands the gravity of the obstacles which must be overcome, and it does not underestimate the difficulty of the mission it faces. Nonetheless, "Healthy Russia 2000" does not shrink from the tasks before it simply because they are difficult. To do so would be to break faith with the people of Russia, who are themselves bravely struggling to create a democratic, free and prosperous society across the board. There is evidence that the high and rising death rates in the former Soviet Union were a major cause of regime instability, and thus a contributing factor to the collapse of the Communist dictatorship. But high death rates can also cause instability in Russia's newly-emerging democracy, threatening a return to the discredited old ways. This result

must be avoided, and it counsels against being overly cautious or pessimistic about the prospects for success.

Moreover, the process of restructuring has already begun, although in a fragmentary, erratic and spontaneous manner. In many places, privately-owned pharmacies are selling to consumers, and some physicians have already been providing fee-for-service medicine to their patients for decades. Polyclinics and hospitals have asked for advice and assistance on how to privatize. Pilot projects are underway in a variety of medical fields and Russian regions, to show the benefits that will flow from reform. Substantial authority and responsibility have already devolved from the central government to regional and local authorities. Financing mechanisms and the provision of health insurance (public and private) have begun to shift. These efforts are proceeding even in the face of massive economic, legal and logistical difficulties, and their ultimate success will largely depend on supportive changes throughout the health-care system.

"Healthy Russia 2000" recognizes that not all aspects of the health-care industry can be treated in exactly the same way. Some aspects (such as the manufacture, distribution and retailing of pharmaceuticals) should be fully privatized on an accelerated basis. Other aspects (such as polyclinics) will be somewhat more complicated. Still others (such as entire hospitals) will be amenable to a range of alternatives, from for-profit ownership, to tax-exempt non-governmental organization, to municipal or regional ownership. The fact remains, however, that the process of reform must begin, and must begin now, capitalizing on Russia's unique experiences and present knowledge, and the expected advances of the next decade.

"Healthy Russia 2000" describes the current state of health in Russia (Section II), and explains the current health-care system (Section III). It then examines the results of extensive survey research to discuss the perceptions of Russian consumers and professionals, and what these opinions can tell us about the present situation and future prospects (Section IV). Finally, "Healthy Russia 2000" describes the new approach to health-care (Section V), and how it will be implemented (Section VI). Extensive Annexes provide supporting information and resource materials.

SECTION II

RUSSIA'S CURRENT STATE OF HEALTH

The Russian Federation is a multi-national state with a total area of more than 17 million square kilometers, and a population of approximately 148,600,000. Seventy-eight percent live in the European areas, 22% in the Asian areas, and 73.3% live in urban regions. Health in Russia, as compared to the developed countries, is characterized by:

- shorter life expectancy;
- higher illness and mortality rates among working-age persons (especially among men) from cardiovascular and oncologic diseases, accidents, intoxication, injury, murders and suicide;
- higher infant mortality rate;
- high rates of illness and mortality from illnesses of the respiratory and digestive systems and infectious diseases among infants and young children; and
- weakening of the immune system of the population because of environmental pollution; alcohol abuse, and allergies among youth.

In short, the health of Russia population is in a dismal state, and is continuing to deteriorate.

Different types and levels of public health-care vary from territory to territory. These differences are most clearly evident in the following regions:

- The rayons with traditionally compact industrial development, established social infrastructure and complicated ecological situations: North-Western, Central and the Urals economic rayons.

- The rayons with developed industry, but in which local centers alternate with vast, thinly populated regions, with difficult ecological situations and unfavorable natural conditions: Northern, West-Siberian, East-Siberian and Far East economic rayons.

- Agricultural/industrial territories with unfavorable ecological situations in rural areas (such as inefficient utilization of pesticides and fertilizers, or poor organization of cattle breeding farms): Volga-Vyatsky, Central Black-Earth and Povolzhsky economic rayons.

- Based on a comprehensive analysis of health indicators, the hazardous regions are: Tuva, Khabarovsk region, Sakhalin oblast, Kemerovo oblast, Irkutsk oblast, Krasnoyarsk region, Komi Republic, Magadan oblast, Tomsk oblast, and Novgorod oblast.

In addition, there are regional differences in the levels and rates of illness and mortality. Thus, in 1992 the mortality rate in Russia was 12.2 per 1,000 people. This index varied from 9.6 in the Far East to 14.3 in the Central Black-Earth region, while among administrative territories it varied from 5.7 in Chukotsky national okrug to 16.6 in Pskov Oblast. In 1993, for the first time in post-war history, more people died in Russia than were born, and the population declined by 800,000.

In 1993, the infant mortality rate was 19.1 per 1,000 newborns, compared to 7.4 in Western countries. The index fluctuated from 15.6 in the Northwestern rayon to 20.8 in the East Siberian rayon. On the oblast level, the fluctuations are even greater, from 14.1 in the Karachaevo-Cherkessk Republic to 32.3 in Tuva. Regional differences are also evident in the rates of illness and mortality from infectious, parasitic, and oncologic diseases, and diseases of the digestive system.

Since 1992, the birth rate has decreased from 10.7 to 9.2 per 1,000 people, the general mortality rate has increased from 12.2 to 14.6 per 1,000; at the same time 1.4 times as many people died as the result of trauma and intoxication as in 1992. The major causes of death are endogenous diseases (blood circulation diseases, malignant neoplasms and some others). For example, in the Murmansk oblast in 1993 the birth rate fell from 10.9 in 1990 to 7.2, the general mortality rate grew from 7.5 in 1992 to 9.9, and the incidence of narcotic-related disorders increased by 25.4%. A decrease in the birth rate, and an increase in mortality rate for young working-age people will result in an increased share of the elderly in the total population. As a result, the number of chronic care patients will grow.

As for preventive care, the highest priority must be given to the prevention of non-infectious diseases, since 96 out of every 100 deaths result from non-infectious diseases. High hospitalization rates and long hospital stays (at least 24 days for therapy and 13.5 for surgery) suggest there is a particularly low level of preventive and primary care, although hospitalization rates appear to be declining (from 25.5 per 100 people in 1985 to 21.8 in 1993). The high mortality rate from infectious diseases, in relation to rates in developed countries, results, in large measure, from the very same unfavorable life conditions which also cause non-infectious diseases:

- Unhealthy life style (poor nutrition, in particular: shortages of proteins, vitamins, vegetable fat and nutritional fibers; smoking, alcohol abuse, and insufficient physical exercise);
- Unfavorable ecological factors, especially in industrially developed areas;
- Unfavorable sanitary and hygienic conditions at manufacturing enterprises;
- Psycho-social stress, caused by the socio-economic difficulties of this transitional period; and
- Deterioration in the quality of medical services while the health-care system is being restructured.

A. MAJOR DISEASES

Infectious Diseases. Compared to developed countries, the rate of acute intestinal infections, such as salmonella and viral hepatitis, is higher, particularly in regions with unfavorable social, economic, sanitary and ecological conditions such as Dagestan, Chechnya, Ingushetia, Siberia, Tuva, and Buryatia. Tuva is one of the leaders in prevalence of type "A" and "B" hepatitis as well as intestinal infections. The rate of diphtheria and measles continues to rise in all of the administrative areas, particularly in overpopulated areas such as Moscow and St. Petersburg. Diphtheria cases alone grew 110 percent in 1992. Children's infections such as pertussis, measles and poliomyelitis persist.

The average rate of tuberculosis in Russia, now considered a social disease, is 34.2 per 100,000, and varies from region to region: from 23.1 in the Northern rayon to 83.7 in Tuva. The highest rates of

tuberculosis are in the Povolzhsky, North-Caucasian and West-Siberian rayons. Over one-third of tuberculosis patients are diagnosed with advanced cases, indicating the importance of prevention.

The rate of natural-focal infections is growing. The major zoogenetic infection is hemorrhagic fever with renal syndrome which has spread to 45 administrative territories in Russia. The highest concentrations are found in Bashkortostan, Udmurtia, and the Mari-El Republic. Natural foci of tularemia continue to exist in Russia (mainly in the Central, Central Black-Earth and Volgo-Vyatsky rayons). In urban centers such as St. Petersburg, pockets of leptospirosis are developing. The natural foci of Russian tick-borne encephalitis are the forest zones of 38 administrative territories, with 85-90 percent of cases now registered in the Urals, East and West Siberia and the Far East.

Parasitic pathology (opisthorchiasis, diphyllobothriasis, etc.) is the most prevalent disease among the populations of the North, Far East and Northern Caucasus areas and, to a significant extent, it defines public health in these areas. The growth rate of syphilis, gonorrhea and other venereal diseases, as well as pediculosis and scabies also serve as indicators of a troubled society.

Oncologic Diseases. The growth rate of illness from cancers in Russia is closely connected both with the general aging of the population and the worsening ecological situation. Early identification is crucial. Among patients diagnosed with original incidences of oncologic disease, those whose cancer is in the first or second stage account for 35.8%. In Russia, "pre-invasive" cancer accounts for 0.4 out of every 100 patients with original incidences of malignancies.

In 1992, the rate was 271.6 cancer cases per 100,000 people. Among men, the primary types are: lung cancer (28.6% of cases), carcinoma of the stomach (15.8%), carcinoma of the skin (7.6%), and hemoblastosis (4.5%). Among women the primary types are: breast cancer (17.4%), carcinoma of the stomach (12.4%), carcinoma of the skin (12.3%) and carcinoma of uterine cervix (5.8%). The rate of disease for men is 1.8 times higher than that for women. The highest rate of cancer is found in the Sakhalin Oblast; among men, in the oblasts of Magadan, Novgorod and Murmansk; among women, in the oblasts of Kaliningrad and Chelyabinsk, and in Tuva and Adygeya. The highest rate

of lung cancer as well as the highest growth rate is in the European areas of Russia such as the Leningradskaya, Nizhijorodskaya and Chelyabinskaya industrial oblasts.

Cardiovascular Diseases. Cardiovascular diseases became the leading cause of death in 1992, at 646.0 per 100,000 people. Ischemic heart disease and cerebrovascular diseases are the largest contributors to mortality, with high blood pressure a leading risk factor. In addition, hyperpietic disease is a significant factor in mortality rates. Approximately 30% of deaths from cardiovascular diseases are among working age persons (ages 20- 59), and roughly 15 percent of school children suffer from high arterial pressure. Mass control over arterial hypertension, timely identification of those who suffer from high arterial pressure, identifying "dislipoproteinemias" and reducing the risk factors will diminish the incidence of cardiovascular pathology.

Mental Health. Psychiatric diseases, including narcological disorder, have long been widespread. The rate of original incidence of psychic disorder cases (excluding alcoholic psychosis, chronic alcoholism, drug abuse and toxomania) was 106.6 per 100,000 in 1992. The rate of original incidence of alcoholic psychosis, chronic alcoholism, drug abuse and toxomania was 107.6 per 100,000. Alcoholism is responsible for 95.9 percent of all cases of mental illness. The rate of registered cases of mental illness in rural areas is 2 to 2.5 times higher than the rate in urban areas. The rayons with the worst mental health situations are the Central, Volgo-Vyatsky, and Central Black-Earth rayons, as well as the West-Siberian and East-Siberian regions. In the last several years, the rate of anxiety, depression and obsessive-compulsive disorders has continued to rise.

Respiratory Diseases. Acute forms of respiratory diseases predominate, one of the major causes of personal disability and economic losses. The primary chronic respiratory diseases are chronic bronchitis, emphysema, pharyngitis, tonsillitis and adenoidal diseases, pneumonia, bronchial asthma and allergic rhinitis.

Diseases of the Digestive System. The rate of diseases of the digestive system is growing. Gastric and duodenal ulcers are the most serious of these diseases.

ЗДРАВООХРАНЕНИЕ В РОССИИ: ВОЗМОЖНОСТИ ИЗМЕНЕНИЙ

Российская общественность в настоящее время находится в крайнем замешательстве из-за выбора, который встал перед потребителями медицинских услуг, и той роли, которую придется сыграть общественности при этом выборе. При простом взгляде на результаты опросов любой может прийти к выводу, что вся российская общественность страдает шизофренией - с одной стороны, они озабочены современным состоянием здравоохранения в России, и проявляются тенденции, которые могут быть интерпретированы как подготовка к реформам; в следующий момент они оказываются абсолютно удовлетворенными состоянием медицинской помощи, которую они получают и утверждают, что все проблемы в России временны и все изменения системы будут огромной ошибкой.

Однако, сопоставление этих кажущихся противоречий не свидетельствует о массовом нарушении психики в России. Более того, эти мнения показывают тот деликатный баланс, который должен быть достигнут в общественном мнении, чтобы убедить россиян в том, что реформы необходимы и благоприятны. Также это доказывает как важно продолжать просвещение российской общественности по вопросам приватизации, чтобы преодолеть неведение и иллюзии, которые возникли в умах людей по поводу реформ и приватизации.

СУЩЕСТВУЮЩЕЕ ПОЛОЖЕНИЕ

Общественное мнение, по-прежнему, негативно при оценке направления развития страны. 61 % россиян утверждают, что нация идет "по неверному пути", и только 22 % считают, что ситуайия развивается правильно. В течение всего года относительное количество граждан, давших негативную оценку, превышало 60 %, что очень много для Соединенных Штатов, но ничего пока не значит в России. Основной контингент респондентов, давших отрицательную оценку развитию реформ в России, составили жители Дальнего Востока, граждане с низким уровнем образования, люди пожилого возроста и с низким уровнем доходов.

Был отмечен заметный рост беспокойства по поводу национального политического руководства, при том, что трое из десяти россиян утверждают, что это самая большая проблема в стране. Почти половина (47%) респондентов, имеющих высшее образование, называют эту проблему основной, также как и молодые люди до 45 лет (37%), респонденты из сельских районов (34%), работающее население (34%), особенно те, кто работает в частном секторе (38 %). Высокие цены (17%), преступность (14 %), и безработица (11 %) также часто упоминаются в качестве главных проблем в России.

Интересно отметить, что когда респондентов просят назвать главную проблему

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лично для них, внимание немедленно переключается на высокие цены (40 %), проблема безработицы остается главной примерно для того же числа респондентов (10 %), проблемы здоровья остаются главными для 10 % респонденитов, и для 7 % главными остаются домашние проблемы. Было отмечено, что основной категорией респондентов, упоминавших о проблемах здоровья, были пожилые граждане, 24 % граждан старше 65 лет и 21 % пенсионеров упомянули об этом. Они также часто упомянают одиночество (16 %) и низкий доход (14%).

Из трех организаций, о которых спрашивалось в ходе опросов общественного мнения, Министерство здравоохранения имеет наиболее выгодную репутацию. Хотя только 12 % отмечают, что Министерство здравоохранения работает "отлично" и "хорошо", 42% оценивают работу Министерства как "удовлетворительную", и только 31% оценивают ее как "неудовлетворительную". Эти данные можно сравнить с тем, что 44% россиян оценивают работу Государственной Думы как "неудовлетворительную", и только некоторые россияне знают достаточно о работе Госкомимущества, чтобы оценить деятельность этого комитета (43% не уверены или не имеют определенного мнения).

Респонденты вполне удовлетворены своими местными поликлиниками, 60% отмечают, что они удовлетворены, и только 31 % не удовлетворены поликлиниками. Удовлетворение местными поликлиниками в городских регионах на 7 процентов выше, чем в сельских (62% против 55%), и на шесть процентов выше среди женщин, чем среди мужчин (62 % и 56% соответственно). Особенно тенденция удовлетворения поликлиниками наблюдается среди женщин пожилого возраста (65%), как и среди тех, кто пользовался бесплатными медицинскими услугами за последние два года (62 %), по сравнению с только 50% среди тех, кто не пользовался ими.

Большинство граждан имеют слабое представление о том, чем занимается их Областное управление здравоохранения (40 %), тогда как одна треть (36%) в настоящее время удовлетворена деятельностью Областного управления, и только 24 % не удовлетворены. Респонденты из сельской местности, люди молодого возраста и жители южных регионов России знают о деятельности Областных управлений здравоохранения больше, и больше удовлетворены их деятельностью и деятельностью их служб на местах.

ИСПОЛЬЗОВАНИЕ МЕДИЦИНСКИХ УСЛУГ

Большинство российских граждан оценивают состояние своего здоровья как вполне хорошее, и только меньше четверти (23%) утверждают, что у них плохое здоровье. Однако, среди тех, кто старше 55 лет этот процент увеличивается до 54%. Этот процент особенно велик среди женщин пожилого возраста, например, 41%

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женщин старше 45 лет утверждают, что
они имеют плохое здоровье, и только 29 % мужчин того же возраста утверждают это (хотя мужчины имеют меньшую продолжительность жизни, чем женщины). 35% малооплачиваемых респондентов указывают, что они имеют слабое здоровье, по сравнению с 15% респондентов со средним уровнем доходов и 10% респондентов с высокими доходами.

82% российских граждан пользовались медицинскими услугами сами (или члены их семей), за которые им не приходилось платить (то, что мы будем называть бесплатные медицинские услуги). Процент сельских жителей, получающих бесплатные медицинские услуги, несколько выше, чем среди городского населения (соответственно 86% и 80%). Частота посещения лечебных учреждений имеет терденцию к повышению, в зависимости от образовательного уровня респондента, поэтому граждане с высшем образованием чаще обращались за медицинской помощью за последние два года (85%).

Считается, что граждане старше 65 лет чаще обращаются за бесплатной медицинской помощью (86%), хотя это только на четыре процента больше, чем среди граждан моложе 45 лет. Среди граждан, имеющих детей, процент тех, кто обращается за бесплатной медицинской помощью на пять пунктов выше, чем среди тех, кто детей не имеет (84% по сравнению с 79%).

Подавляющее большинство тех, кто обращался за бесплатной помощью, обращались в поликлинику (71%), двое из десяти обращались в больницу (20 %). Только восемь процентов были посещены врачом, и один процент - акушеркой. Сельские жители обращаются в больницу чаще, чем городские (28 % против 17 %). Мужчины старше 45 лет обращаются в больницу чаще (27 %), и тенденция к пребыванию в больнице обратно пропорциональна образовательному уровню респондентов.

Восемь процентов (8 %) тех, кто пользовался бесплатной медицинской помощью в последние два года , имели хирургические операции (опять же, чаще это были пожилые мужчины из сельской местности), тогда как почти половина (46 %) получали неотложную помощь или лечение по поводу таких заболеваний, как пневмония (7%), кардиологических заболеваний (6%), обращались для анализа крови (8%), по поводу язвы желудка (6%), и т.д.
Процент тех, кто получал лечение при данных заболеваниях, выше среди пожилых людей, увеличиваясь до 65 % среди тех пациентов, кто старше 65 лет.

Только шесть процентов (6 %) были полностью обследованы, и 6% обращались за педиатрической помощью, 17 % обращались за помощью по поводу незначительных простуд. Эти незначительные жалобы обычно поступали от респондентов младшего возраста (44 % пришлось на долю тех, кому 18-34 года, и

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39% - на долю 35-44-летних), и преимущественно в городских районах (31%).

Другие семь процентов (7%) указали, что они получили бесплатную помощь зубного врача, особенно велик этот процент среди жителей городский регионов (10%) и среди людей с высшим образованием (12%).

Только четырнадцать процентов (14 %) граждан, которые получили бесплатную медицинскую помощь, вынуждены были подарить врачу или медсестре какой-то подарок или заплатить наличными. Эта практика чаще встречается в больших городах (16% таких ответов встречались в городах с населением более 500 000 жителей. Чаще всего подобную практику применяют молодые люди . Об этом говорят 21% тех, кому 18-34 года, 18% тех, кому 35-44 года и 11% тех, кому 45-64 года (только 4 % людей пожилого возраста). Чем выше доход респондента, тем чаще он практикует подобные вознаграждения, процент вырастает до 20 % среди людей с высоким уровнем дохода.

Подавляющее большинство респондентов, которые получили бесплатную медицинскую помощь, остались вполне довольны этой помощью. 44 % заметили, что медицинская помощь была великолепной или хорошей, 46 % говорят, что она была удовлетворительной и только 8% утверждают, что она была плохой. Молодые женщины, респонденты с высшим образованием и жители больших городов чаще квалифицируют помощь, которую они получили, как плохую.

Менее одной четверти респондентов (22%) отмечают, что они получили медицинскую помощь, которую они полностью оплатили. Почти половина (46%) этих медицинских услуг приходится на услуги зубного врача. Много раз упоминались и другие услуги: кардилогия (5%), общее обследование (8%), хирургические операции (3 %), неврологические заболевания (5%), и лечение язвы желудка (4%). Опять же, почти все платные услуги были получены в поликлинике (69 %), в больнице (10 %), и при визите врача (8%). Часто приходится оплачивать услуги акушерок (8 % всех платных услуг).

Качество платных и бесплатных медицинских услуг отличается незначительно. Из тех, кто платил за медицинскую помощь, только 57 % охарактеризовал полученную помощь как прекрасную или хорошую (этот процент немного выше, чем при бесплатных услугах), 27% характеризуют ее как нормальную (ниже) и 12 % характеризуют помощь как плохую (этот показатель на 4% выше, чем при бесплатных услугах).

Некоторые респонденты отметили, что они не обращались за медицинской помощью для себя или своих родственников в последнее время из-за "сомнений по поводу качества медицинских услуг, тогда как в прошлом они бы обратились за медицинской помощью". 15 % опрошенных ответили на этот вопрос

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положительно, ни в одной из опрошенных групп этот процент не опускался ниже 8 %.

Беспокойство по поводу качества услуг чаще всего отмечалось в Дальневосточном регионе (22 %) и в больших городах с населением более 500 000 человек (17 %). Необходимо заметить, что беспокойство возникает не из-за неведения или из-за беспокойства по поводу цен, так как большинство тех, кто утверждал, что они не обращались за медицинской помощью по причине сомнений по поводу качества, относились, в основном, к группам людей с хорошим уровнем образования и высоким уровнем доходов. Почти одна четвертая (23%) опрошенных с высшим образованием не обращались за медицинской помощью из-за сомнений по поводу качества (менее 12 % опрошенных, имеющих незаконченное высшее или среднее образование, говорят то же самое). Также и 18% респондентов с высоким уровнем доходов не обращались за медицинской помощью по причине сомнений в качестве услуг (этот процент уменьшается до 15 % в группе респондентов со средним и низким уровнем доходов).

Можно отметить снижение уровня опасений по поводу качества услуг с возрастом, так 8% опрошенных старшего возраста не обращались за медицинской помощью из-за сомнений по поводу качества услуг, этот процент доходит до 17% среди опрошенных 35-44 лет и до 21% среди опрошенных моложе 35 лет. В семьях, имеющих детей, этот процент составляет 18 % по сравнению с бездетными семьями (13%).

ВЗГЛЯДЫ НА СОВРЕМЕННОЕ СОСТОЯНИЕ ЗДРАВООХРАНЕНИЯ

Большинство российских граждан (55%) указывают, что они не удовлетворены состоянием здравоохранения в стране, и 16 % указывают, что "они абсолютно не удовлетворены". 29 % отмечают, что они удовлетворены здравоохранением и только 9 % опрошенных граждан отмечают, что они полностью удовлетворены. Остальные 12 % не обращались за медицинской помощью в последнее время и не считают возможным вынести суждение.

Следует отметить, что взгляды потребителей медицинских услуг совпадают со взглядами профессионалов-медиков по этому вопросу. 55% врачей, медсестер, администраторов и фармацевтов также указывают, что они не удовлетворены современным состоянием здравоохранения, тогда как 45 % уверяют, что современное здравоохранение их устраивает (так как все опрошенные обладали опытом работы в системе здравоохранения, процент тех, кого данная система удовлетворяет выше среди медиков, чем среди потребителей медицинских услуг, которые могли основывать свои мнения на отсутствии знания системы).

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Однако, в других вопросах, профессионалы намного более негативно настроены, чем потребители услуг. 78 % медицинских работников указывают, что сейчас система здравоохранения менее безопасна, чем десять лет назад. Кроме того, 78 % утверждают, что существующая система здравоохранения не отвечает нуждам россиян.

Потребителям медицинских услуг, которые сказали, что они не удовлетворены состоянием здравоохранения в России, был задан вопрос о том, что является наиболее важной причиной их подобного отношения. Четверть респондентов (25 %) отмечают нехватку лекарственных препаратов, особенно высок этот процент в сельской местности (41%) и среди людей старшего возраста (42 %). Двое из десяти россиян отмечают грубое и безответственное отношение врачей как самую большую проблему существующей системы. На эту проблему обращают внимание жители городов (24 %), особенно - больших городов (31%). Двенадцать процентов (12%) отмечают некомпетентность части врачей, в основном, об этом говорят респонденты молодого возраста и с высоким уровнем доходов. Отмечается и множество других причин: устаревшее оборудование (7%), длинные очереди и долгое ожидание врачебной помощи (8 %), отсутствие специалистов (3 %), и высокие цены (5 %).

Необходимо отметить, что когда респондентам давался список проблем здравоохранения и их просили поставить эти проблемы в порядке уменьшения важности, на первое место выходила проблема "оснащения больниц и поликлиник необходимым оборудованием и лекарствами" (39 %). Обеспокоенность этой проблемой наблюдалась в сельских районах, где ее ставили на первое место 49 % опрошенных. Следующей большой проблемой стала проблема загрязнения окружающей среды. Опрошенные выражают желание, чтобы центральные власти обратили внимание на эту проблему (16 % опрошенных). Каждый десятый россиянин хочет, чтобы Правительство обратило внимание на проблему обучения и подготовки врачей и медицинских сестер по самым современным лечебным методикам, 5 % указывают, что главной проблемой является работа фармацевтических предприятий, тогда как остальное не получает большой поддержки. Остальные 22 % граждан придерживаются того подхода, что необходимо обратить внимание на сочетание проблем.

Однако, в тех случаях, когда респондентов просили назвать основные проблемы, которые встают лично перед ними, на первое место встает проблема материальная. Трое из десяти россиян отметили, что их больше всего беспокоит вероятность того, что "у правительства будет недостаточно денег, чтобы финансировать систему здравоохранения, и нам придется платить за лечение больше".

Семьдесят процентов (70 %) россиян отмечают, что они "очень" беспокоятся

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по поводу того, что "от них могут потребовать заплатить" за основные медицинские услуги. И подавляющее большинство опрошенных (81 %) отмечают, что они боятся того, что они будут не в состоянии заплатить за медицинскую помощь, если они сами или члены их семей "будут страдать от серьезного заболевания в будущем". Данное опасение по поводу возможности оплаты медицинской помощи в существующих экономических условиях прослеживается в ответах, независимо от географических или демографических показателей. Только респонденты с высоким уровнем доходов меньше отмечают эту проблему, и в этой группе населения процент беспокойства по двум вышеупомянутым причинам, в среднем, на 20 % ниже.

Долгое ожидание медицинской помощи уже не является столь большой проблемой, как в прошлом, почти половина опрошенных граждан (49 %) отмечают, что им никогда не приходится ждать приема у врача и т.д. Самый большой срок ожидания, упоминавшийся при опросе, составлял месяц или более , хотя только 5 % имели подобный опыт. Из тех, кто был вынужден ждать неделю или дольше (13 %), большинство живут в больших городах (22 %) и охарактеризовали медицинскую помощь, которую они получают, как плохую (22 %).

Ожидание приема у врача по прибытии в лечебное учреждение обычно составляет менее трех часов, 40 % утверждают, что им приходится ждать час и меньше, 27 % говорят, что они вынуждены ждать 1-2 часа, и только 7% утверждают, что они вынуждены были ждать 3 часа и более. Остальные 13 % говорят, что им не приходилось ждать и 11 % не обращались за медицинской помощью.

Респондентам был также задан вопрос о доступности лекарственных препаратов за последний год или полгода. 41 % отмечают, что положение ухудшилось, тогда как это утверждают 52 % медицинских работников. Обе группы респондентов, живущие в сельской местности, гораздо чаще отмечают дефицит лекарств, чем те, кто живет в городах, также как и те, кто живет в Дальневосточном регионе. Трое из десяти россиян утверждают, что положение с лекарствами за последний год или полгода улучшилось, и 17 % утверждают, что оно осталось прежним.

Сорок два процента (42 %) опрошенных говорят, что качество лекарственных препаратов осталось на прежнем уровне, 18 % отмечают, что оно улучшилось и 10 % говорят об ухудшении качества. Жители городов чаще отмечают ухудшение качества лекарственных препаратов, чем жители сельской местности. Однако, респонденты молодого возраста и с высоким уровнем образования отмечают улучшение качества лекарственных препаратов.

Респонденты, безусловно, хотели бы покупать предметы косметики в аптеках

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(36 %), и только 16 % отметили, что они будут покупать их там, где и сейчас. Эту идею лучше принимают в Уральском и Сибирском регионах (47 %) и в городах с населением от 50 до 100 тысяч жителей (51 %). Мужчины и женщины моложе 45 лет (41 % в каждой категориии) также лучше воспринимают эту идею, чем те, кто старше 45 лет (27 % и 34% соответственно).

ВЗГЛЯДЫ НА СТРАХОВУЮ МЕДИЦИНУ

Только немногим более половины россиян (57 %) видели, читали или слышали что-либо о Законе об обязательном медицинском страховании, который был принят в прошлом году, и этот уровень на тридцать процентов ниже, чем среди медицинских работников (88 %). Этот процент граждан, что-либо знающих о Законе, выше 50 во всех регионах страны, особенно высок он (83 %) на Дальнем Востоке. В городах этот процент составляет, в среднем, 60 %, тогда как в сельской местности - только 49%.

Респонденты с более высоким уровнем образования также уделяют этому вопросу больше внимания: 75 % респондентов с высшим образованием отмечают, что они слышали о Законе, этот процент уменьшается до 63 среди выпускников техникумов и до 52 - среди выпускников средней школы. Только 41 % тех, у кого образование ниже средней школы, слышали о данном законе.

Также, респонденты с более высоким уровнем доходов слышали о законе больше (75 %), чем респонденты со средним уровнем доходов (64 %), и только 48 % респондентов с низким уровнем доходов что-либо слышали о данном законе. Респонденты среднего возраста обнаружили большую осведомленность по этому поводу, чем более молодые или более старые. Тогда как 60 % граждан в возрасте 35-64 лет утверждают, что они видели, читали или слышали что либо о Законе об обязательном медицинском страховании, среди граждан в возрасте моложе 35 лет таких только 58 %, а в возрасте старше 65 - только 38%.

Респонденты, не удовлетворенные состоянием системы здравоохранения или лучше относящиеся к идее реформ здравоохранения, также уделяют больше внимания данному вопросу. 61 % из этой группы отметили, что они слышали о новом законе. Среди тех, кто удовлетворен состоянием здравоохранения или осторожно относится к идее реформ, процент знающих о законе составил всего 47.

Среди тех респондентов, которые видели, читали или слышали что-либо о Законе об обязательном медицинском образовании, 61 % также знают и о системе добровольного медицинского страхования, предусмотренной в законе и позволяющей расширить систему применения страховой медицины при помощи добровольного страхования, в дополнение к обязательному. Опять же,

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осведомленность определяется уровнем образования, среди респондентов с высшим образованием процент осведомленных о новом законе составил 71 %. И этот процент снижается до 47 % среди тех, кто не имеет высшего образования и знает о законе.

Опрошенные граждане более старшего возраста знают о законе меньше, чем более молодые (только 50 % граждан старше 55 лет знают об этом аспекте законодательства). Молодые женщины моложе 45 лет лучше информированы о страховом законодательстве (среди них показатель составляет 67%).

Кроме того, неудовлетворенные здравоохранением респонденты знают о новом законодательстве больше, из них 61 % что-либо видел, читал или слышал о законе. И среди тех, кто удовлетворен существующей системой здравоохранения, этот показатель ниже на 4 %.

Потребители медицинских услуг положительно оценивают новое законодательство по здравоохранению в России. 38 % респондентов, которые знают о законе, утверждают, что он улучшит положение, хотя только 6 % абсолютно уверены в этом. Эти цифры можно сравнить с 29 % среди медицинских работников, которые считают, что новый закон окажет благоприятное действие на существующую систему здравоохранения. Только один из десяти россиян утверждает, что изменения здравоохранения, определенные законом, ухудшат систему (по сравнению с 33 % медицинских работников, которые считают, что изменения окажут отрицательное влияние). Приблизительно четверть (26 %) граждан отмечают, что новый закон ничего не изменит в здравоохранении, тогда как другие 26 % не уверены в том, какой эффект он будет иметь.

Респонденты из сельской местности более позитивно оценивают влияние нового закона на состояние российского здравоохранения, так как 44 % предполагают, что он улучшит здравоохранение, и только 36 % городских жителей говорят то же самое. Жители южных регионов России (40 %) и Дальнего Востока (39 %) также имеют более позитивное отношение к данной проблеме.

Возраст является определяющим фактором при формировании отношения к данной проблеме, и у молодых людей отношение более благоприятное. Почти половина (48 %) респондентов моложе 45 лет считают, что новый закон улучшит систему здравоохранения, и этот процент снижается до 40 среди людей среднего возраста и до 26 - среди респондентов старше 55 лет.

Существует некоторое различие между отношением к новому законодательству у мужчин и женщин. 41 % мужчин считают, что новый закон о медицинском страховании приведет к улучшениям в системе здравоохранения,

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тогда как процент оптимистически настроенных женщин на 5 процентов ниже (36 %). Это также справедливо и для граждан моложе 45 лет (49 % мужчин и 42 % женщин).

Другие группы респондентов, которые положительно относятся к закону и его влиянию на систему здравоохранения, - граждане с высоким уровнем доходов (53 %), семьи с детьми (44 %), выпускники техникумов (45 %), респонденты, которые считают, что управление здравоохранением со стороны бизнеса улучшит систему (52 %), и те, кто считает, что система в любом случае улучшится в ближайшие 10 лет (61 %).

ОБЩЕСТВЕННОЕ ПРОСВЕЩЕНИЕ И КАМПАНИИ ПО ПРОФИЛАКТИКЕ

Две трети (66 %) граждан видели, читали или слышали что-либо о правительственных кампаниях общественного просвещения "по проблемам здравоохранения, которые определяют здоровый образ жизни, такие как борьба с курением и алкоголизмом..." Об этих усилиях знают более 60 % населения во всех регионах, особенно - в южных регионах России, где 71 % респондентов знает об этих правительственных программах.

Респонденты молодого возраста обычно знают об этих правительственных усилиях больше, чем пожилые граждане. 71 % граждан моложе 35 лет заявляют, что они видели, читали или слышали что-либо о предпринимаемых усилиях. Осведомленность среди категории граждан 35-64 лет падает до 66 %, и до 58 % среди тех, кому больше 65 лет. Осведомленность также прямо пропорциональна образовательному уровню, так 71 % респондентов с высшим образованием слышали о проведении этих кампаний. Однако, уровень доходов не является определяющим фактором в осведомленности граждан.

Респонденты, имеющие детей (70 %), те, кто не удовлетворен уровнем здравоохранения и кто позитивно относится к реформам (69 %) и те, кто обращался за медицинской помощью для себя или членов семьи за последние два года (67 %). Следует отметить, что три четвертых из тех, кто слышал о законе о медицинском страховании, также осведомлены о предпринимаемых усилиях по общественному медицинскому просвещению.

К сожалению, высокий уровень осведомленности не свидетельствует об эффективности. Менее одной четверти (24 %) респондентов, знающих о правительственных программах, отмечают, что они побудили их "изменить какие-либо привычки или вести себя иначе". Кампании оказали более благоприятное влияние на молодых граждан. 30% из тех, кому 18-34 года заявили, что информация, полученная в результате кампаний по общественному просвещению,

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заставила их изменить свои привычки. Этот показатель падает до 25 % среди респондентов среднего возраста и до 16% среди опрошенных старшего возраста. Женщины моложе 45 лет оказались особенно восприимчивы к информации (30 %), этот процент на 5 больше, чем среди мужчин того же возраста. Пол или уровень доходов почти не влияет на этот показатель. Однако, программы имеют больший эффект среди сельского населения (27%), чем среди городских жителей (23 %).

Общественность уже хорошо осведомлена о положительных моментах профилактической медицины, и 71 % граждан согласны с тем, что "лучше предотвратить болезнь, обратившись к врачу один раз в год для обследования, занимаясь спортом и питаясь правильно". Только 11 % согласны с мнением, что " к врачу следует обращаться только в случаях болезни. Кроме того, занятия спортом и изменение привычек приносят больше беспокойства и не очень помогают". 13 % утверждают, что обе точки зрения имеют одинаковое значение.

Единственной группой, отвергающей преимущества профилактической медицины, является категория пожилых людей. 18 % опрошенных 55-64 лет и 14 % тех, кому больше 65 лет, поддерживают точку зрения о том, что профилактика - скорее беспокойство, чем помощь. Этот показатель выше среди пожилых мужчин, чем среди пожилых женщин (16 % и 13 % - соответственно). Отрицательное отношение также определяется более низким уровнем образования (кто, в целом, старше), так 16 % опрошенных с незаконченным высшим образованием и 13 % опрошенных с высшим образованием склонны думать, что профилактика не приносит пользы.

Следует отметить, что респонденты, имеющие детей и поддерживающие меры по профилактике, имеют показатель, который на 10 % превышает тот, который зарегистрирован среди бездетных респондентов (76% и 66% соответственно). Граждане с высоким уровнем дохода и работающие не на производстве также более склонны поддерживать профилактические мероприятия.

Для сравнения, 80% тех, кто имеет детей, отмечают, что они получили все необходимые прививки, тогда как 16 % отмечают, что получили только некоторые прививки, и только 4 % заметили, что не делали прививок. Хотя может случиться, что респонденты отвечали так "по политическим мотивам", но их ответы свидетельствуют, что они убеждены в правильности профилактических мероприятий. Единственным регионом, где уровень вакцинации ниже, является Уральско-Сибирский регион, где лишь 69 % ответили, что их дети имеют все прививки.

БУДУЩЕЕ ЗДРАВООХРАНЕНИЯ

При всех опасениях, высказанных по поводу современного состояния

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здравоохранения, удивительно то, что россияне весьма оптимистичны при попытках предсказать будущее здравоохранения. Общественность склонна думать, что в ближайшие десять лет состояние системы здравоохранения скорее улучшится (32 %), чем ухудшится (21 %), или останется на прежнем уровне (21 %). Однако, 26 % не смогли ответить , какой будет ситуация через десять лет.

Молодые российские граждане склонны к оптимистическим прогнозам по поводу развития системы здравоохранения в России. Чем моложе респонденты, тем большее их количество считает, что положение улучшится, 41 % граждан 18-34 лет считают так, и только 26 % тех, кому больше 65 лет, поддерживают эту точку зрения. Оптимистический взгляд на ситуацию также прямо пропорционален уровню доходов. 27 % респондентов с низкими доходами, 34 % со средними доходами и 40 % с высокими доходами придерживаются оптимистической точки зрения.

Следует отметить, что большинство респондентов склонны рассматривать существующие проблемы здравоохранения как временные. 54 % граждан согласны с утверждением, что "Система здравоохранения, существующая в России, хороша, и все ее проблемы временны", 35 % граждан с этим не согласны.

Эта точка зрения больше поддерживается в сельских районах (60 %), чем в городских (52 %). Этот показатель держится на уровне приблизительно 50 % во всех регионах страны с незначительными отклонениями, зависящими от пола, возраста и доходов респондентов. Меньшую роль в этом играет уровень образования, однако несколько меньшее количество граждан с высшим образованием (49%) склонны согласиться с мыслью, что проблемы лишь временные.

По категориям респондентов, удовлетворенных ситуацией и не согласных с реформами , 74 % согласны с тем, что проблемы российского здравоохранения временны, и только 15 % не согласны с этим. Однако, среди тех, кто более позитивно относится к реформам, этот процент составляет только 50 %, и 41 % не поддерживают идею о временности проблем. Но это еще один фактор, указывающий на возможность убедить эту группу поддержать реформы.

СРАВНИТЕЛЬНЫЕ ХАРАКТЕРИСТИКИ

Качество

Респондентов также просили сделать выбор возможных изменений в системе здравоохранения. Большинство россиян (55 %) указывают, что в первую очередь необходимо соблюсти принцип "сохранения бесплатной медицины для всех

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россиян", а потом уже думать о принципе "будь уверен, что медицинские услуги, которые получаешь ты и члены твоей семьи, имеют высокое качество, и оно останется высоким, даже если придется заплатить" (40 %).

Опять же, многое в отношении к этой проблеме зависит от возраста, как можно убедиться по данным показателям:

ВОЗРАСТ	БЕСПЛАТНО	КАЧЕСТВЕННО
18-34	38%	57%
35-44	40%	54%
45-54	57%	38%
55-64	71%	22%
65 и более	82%	13%

С возрастом наблюдается заметный рост беспокойства по поводу затрат и желание сохранить статус-кво. Этот процент слегка выше среди женщин старше 45 лет (73 % выступают за бесплатную медицину), чем среди мужчин того же возраста (67 % - за бесплатную медицину).

Граждане с высоким уровнем образования скорее выступают за принцип качествва медицинских услуг, даже если они станут слегка дороже. 50 % выпускников техникумов и 55 % выпускников ВУЗов утверждают, что вопрос качества важнее принципа бесплатности (45 % и 39 %, соответственно). Это мнение в корне отличается от мнений людей с более низким уровнем образования, среди которых только 17 % отмечают первенство фактора качества, тогда как 80 % считают, что принцип бесплатности более важен.
Безусловно, уровень доходов также влияет на отношение к данному вопросу, и те, кто способен заплатить, выражают большее желание платить.

Необходимо отметить, что Дальний Восток является единственным регионом, где и за принцип бесплатности и за принцип качества выступает одинаковое количество респондентов (по 45 %).

Однако, когда опрашиваемым задавали вопрос, предпочтут ли они систему, при которой основные услуги предоставляются бесплатно, а за другие придется платить, но качество услуг повысится (59 %), или систему, при которой все медицинские услуги останутся бесплатными, но и качество останется прежним (36 %), выяснилось, что граждане готовы пойти на некоторые жертвы. Так, можно утверждать, что определенный набор основных медицинских услуг должен оставаться бесплатным, с тем, чтобы не возникало опасений смогут ли россияне позволить себе обратиться за медицинской помощью. Они привыкли к некоторым ограничениям, но в настоящее, неспокойное с экономической точки зрения, время

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беспокоятся, что не смогут заплатить за услуги.

Опять же, возраст значительно определяет отношение к данному вопросу. Приблизительно 73 % респондентов моложе 45 лет согласны на некоторые ограничения при улучшении качества, этот процент уменьшается до 65 среди граждан 45 54 лет, до 43 среди граждан 55-64 лет, и лишь до 33 % среди граждан более старшего возраста. Респонденты в возрасте старше 55 лет вообще против введения каких-либо ограничений на бесплатную медицинскую помощь (52 % граждан 55-64 лет и 61 % граждан более старшего возраста), не взирая на вопрос о качестве.

Граждане с высоким уровнем образования отмечают проблему улучшения качества медицинских услуг, как первостепенный. Более 70% выпускников техникумов и ВУЗов согласны на некоторые ограничения в области бесплатной медицины, при условии улучшения качества, тогда как на это согласны лишь 62 % граждан со средним образованием и только 37% с более низким образованием.

Лица, работающие в частном секторе, (77 % - за ограничения), с высоким уровнем доходов (78 %), имеющие детей (69 %), мужчины (64 %), городские жители (61 %) также имеют тенденцию больше внимания обращать на качество медицинских услуг.

Расходы

Большинство россиян выступает против того, чтобы частные лица платили за здравоохранение, хотя около 40 % населения в настоящее время предпочитают проведение реформ или уверены, что в результате их система останется на том же уровне, что и сейчас. 53 % граждан согласны с точкой зрения, что "люди не должны платить за основные медицинские услуги, так как они не могут себе этого позволить, и должны платить лишь за дополнительные удобства", как-то - отдельные палаты или углубленные методы лечения. 21 % более склонны согласиться с идеей, что "только пациенты, оплачивающие медицинские услуги, могут создать конкуренцию среди врачей и тем самым заставить их улучшить качество услуг, оставив цены на доступном уровне". Остальные 22 % респондентов относятся к обоим точкам зрения одинаково.

Очевидно, что россияне более старшего возраста придерживаются консервативных взглядов и более озабочены вопросом оплаты, чем их молодые сограждане. 67 % граждан старше 65 лет и 64 % в возрасте от 55 до 64 лет считают, что люди не должны платить. Эту точку зрения поддерживают 55 % тех, кому 45-54 года, 48 % тех, кому 35-44 года и только 40 % тех, кому меньше 35 лет. В последней группе опрошенных 29 % согласны с точкой зрения, что оплата услуг

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является единственным средством организации конкуренции и поднятия уровня качества - это один из самых высоких показателей среди всех опрошенных групп.

Респонденты с низким уровнем образования, например 66 % тех, у кого образование ниже средней школы, поддерживают идею бесплатной медицины для всех. Этот показатель значительно ниже среди респондентов с высшим образованием (приблизительно 48 %).

По данному вопросу почти нет разницы между мнением городского и сельского населения. Однако, россияне, живущие в Центральном и Северном регионе страны, больше поддерживают идею бесплатной медицины (58 %), чем, те, кто живет в Южном регионе (52 %), на Урале и в Сибири (47 %), и на Дальнем Востоке (51 %).

Процент женщин, поддерживающих идею бесплатной медицины, больше, чем процент мужчин (55 % и 49 %, соответственно). Эта разница заметна и между категориями молодых и пожилых женщин.

Респонденты, работающие в частном секторе экономики (36 % поддерживают идею оплаты), переходят из государственного в частный (31 %), имеющие детей (25 %) или те, кто не удовлетворен современной системой (22 %), более позитивно относятся к идее, что оплата медицинских услуг является единственным способом создать конкуренцию и повысить качество медицины.

46 % россиян отметили, что они все равно ходили бы в местную поликлинику, даже если бы не было проблем с оплатой, хотя 22 % указали, что они бы посещали местного частного врача. Только 10 % озабочены проблемой месторасположения лечебного учреждения при ответе на вопрос, посещали бы они поликлинику в другом городе. Большинство положительных ответов исходит от жителей сельской местности (18 %).
Также как, среди желающих посещать частного врача в другом городе процент сельских жителей составляет 12.

Ходить в местную поликлинику предпочитает большинство респондентов во всех регионах страны, разница в процентном отношении не составляет более двух пунктов. Как было указано ранее, сельские жители относятся к идее посещения поликлиники в другом городе более благосклонно (18 %), поэтому они реже поддерживают идею посещения местной поликлиники, чем городские жители (42 и 48 %, соответственно). Идею частных врачей больше поддерживают в Дальневосточном регионе (36 % высказались за посещение местного частного врача или врача в ближайшем городе), на Урале и в Сибири (31 %), в Центральной и Северной России (31 %). Желание посещать частного врача, если бы оплата не была проблемой , высказали 24 % жителей южных регионов России. В целом, этот

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процентный показатель в городских районах на 8 пунктов выше, чем в сельской местности (соответственно, 32 и 24 %).

Возраст и образовательный уровень также оказывают большое влияние на отношение респондентов к идее посещения частных врачей. Среди молодых граждан этот процент составляет 35, тогда как среди более пожилых этот показатель снижается до 16 %. Также и среди людей с высшим образованием процент желающих посещать частного врача, если бы не проблемы с оплатой, на 16 пунктов выше, чем среди менее образованных граждан.

Можно отметить, что несмотря на то, что вопрос оплаты не должен рассматриваться как решающий фактор при выборе ответа, уровень доходов оказывает большое влияние на решение. Желание посещать частного врача на 17 процентов выше среди граждан с высоким уровнем доходов, чем среди тех, у кого доход более низкий. И кроме того, к этой категории обычно относятся престарелые граждане и пенсионеры , что может являться решающим фактором при принятии решения - у них нет возможности платить.

Среди респондентов, не удовлетворенных уровнем здравоохранения, только 39 % по-прежнему будут посещать местную поликлинику, даже если бы вопрос оплаты не рассматривался, 35 % выбрали бы частного врача, и 12 % посещали бы поликлинику в ближайшем городе. Среди респондентов, удовлетворенных уровнем медицины и осторожно относящихся к идее реформ, большинство удовлетворены своей местной поликлиникой (66 %), тогда как только двое из десяти хотели бы посещать частного врача и 2 % согласны посещать другую поликлинику.

Респондентов спросили о том, за какие дополнительные процедуры или лечение, исключенные из списка финансируемых государством основных медицинских услуг, они согласились бы платить дополнительно. Результаты данного опроса иллюстрирует следующая диаграмма:

ПРОЦЕДУРА	ДА	НЕТ
Психиатрическая помощь	31 %	58%
Контрацептика/Планирование семьи	35	48
Лечение алкоголизма	37	49
Профилактический осмотр	36	57
Педиатрия	45	49
Подбор очков/Проверка зрения	45	46

Как ясно видно из этой таблицы, существует большое нежелание платить за что-либо. Однако, значение всего этого может быть не совсем ясно, так как вопрос мог быть интерпретирован по-разному. Например, один может считать данный вид лечения жизненно важным и поэтому правительство должно субсидировать его, как например - педиатрия; другой же может считать, что даже если какая-то процедура

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респондента к той или иной проблеме, с возрастом желание посещать лечебные учреждения, управляемые "медицинскими трастами", уменьшается. 58 % молодых респондентов готовы посещать некоммерческие неправительственные лечебные учреждения, тогда как среди пожилых респондентов таких - только 49 %.

Среди респондентов, удовлетворенных состоянием здравоохранения, 44 % относятся к этой идее положительно и 40 % - отрицательно. Среди тех, кто не удовлетворен состоянием здравоохранения, это соотношение составляет 58 % и 32 %.

Положительно к подобным лечебным учреждениям относятся 63 % неработающих, 57 % имеющих детей, 59 % с высоким уровнем доходов.

Затем респондентам был задан вопрос об их возможных действиях, "если бы лечебное учреждение управлялось частной группой, например - группой врачей, которые работают там же, но при этом данная группа извлекала бы доход из этого при успешной работе". В этом случае, процент желающих тот же, что и при предыдущем вопросе (55 %). По крайней мере, этот аспект ничего не добавляет к предыдущим данным.

Добавление эпитета "коммерческий" имеет интересный эффект на некоторые группы опрашиваемых россиян. Географически, он несколько уменьшает процент респондентов в сельской местности (54% 9), особенно в южных регионах (56% -6). Однако, этот незначительный признак капитализма несколько увеличивает процент городских жителей, поддерживающих эту идею (55% +3), жителей Дальнего Востока (60% +8), и жителей Урала и Сибири (57% +9). Положительное отношение к этим реформированным учреждениям незначительно меньше в Центральном и Северном регионах России (-2).

Добавление эпитета "коммерческий" имеет резко отрицательное влияние на реакцию пожилых людей, хотя происходит обратное при опросах молодых :

ВОЗРАСТ	КОММЕРЧЕСКИЕ/ДА	РАЗНИЦА С НЕКОММЕРЧЕСКИМИ
18-34	67%	+9
35-44	59	+3
45-54	58	+2
55-64	45	-7
65 старше	39	-10

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стоит каких-то денег, то она ему не нужна, как например - лечение алкоголизма.

Если оставить в стороне эти рассуждения, четко прослеживается тенденция нежелания платить за два вида процедур: психиатрическую помощь и профилактические осмотры. Однако, только 35 % потребителей услуг заявили о своей готовности оплачивать контрацептику и планирование семьи, тогда как 66 % медицинских работников утверждают, что пациенты должны платить за это.

Те, кто готов оплачивать большинство лечебных процедур, относятся к группе граждан с высоким уровнем дохода, младше 45 лет, с высшим образованием, и работающих в частном секторе экономики. Процент мужчин, готовых оплачивать медицинские услуги, обычно несколько выше, чем среди женщин.

Типы лечебных учреждений

В следующей части опроса, респондентов просили сделать выбор на основе возможных реформ российской системы здравоохранения. Сначала, респондентам рассказали о "медицинских трастах" следующим образом: "Обсуждалась идея создания некоторых поликлиник и больниц, которые управляются не государственными органами, а своего рода "Медицинскими трастами". Это значит, что правительственные органы контролируют некоторые стандарты, как-то безопасность, управление больницей находится в руках церковной общины, благотворительной организации, союза или другой частной группы, не извлекающей дохода из данного предприятия."

Большинство россиян (55%) ответили, что они согласились бы посещать подобные больницы и поликлиники, управляемыми такими организациями, 17 % выразили сильное желание. Только треть опрашиваемых (33 %) отказалась посещать подобные лечебные учреждения и 12 % резко отказались.

Жители сельской местности более благосклонно относятся к идее лечения в некоммерческих лечебных учреждениях (63 % согласны посещать лечебные учреждения "медицинских трастов", и только 25 % не согласны). Положительно к этому относятся 52 % городских жителей, и 35 % - отрицательно. 62 % жителей южных регионов относятся к этому положительно, по сравнению с 54 % жителей Центрального и Северного регионов России, 52 % жителей Дальнего Востока и только 48% респондентов из Уральского и Сибирского регионов.

Отличие процентного показателя среди мужчин и женщин незначительно (соответственно 57 и 53 %). Пожилые женщины относятся к этой идее наиболее отрицательно, только 50 % утверждают, что они согласны, и 35 % - нет.

По-прежнему, возраст играет основную роль в определении отношения

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Эпитет "коммерческий" имеет вполне благоприятную реакцию среди более образованных респондентов. 67 % выпускников ВУЗов и 60 % выпускников техникумов согласны посещать частные коммерческие лечебные учреждения, разница достигает 9 и 7 пунктов, соответственно. Респонденты имеющие среднее или неполное среднее образование, относятся к этой идее менее благосклонно (-4 и -9, соответственно).

Эта идея имеет несколько неожиданную реакцию в некоторых группах опрошенных - отрицательную реакцию среди неудовлетворенных системой (-2) и положительную - среди тех, кто удовлетворен системой здравоохранения (+5).

Среди тех, кто отказался бы обращаться в частные, коммерческие больницы или поликлиники , 36 % отмечают, что они не пойдут туда по причине отсутствия денег. Эта причина является самой важной для сельских жителей (56 %), для тех, кто старше 55 лет(45%), престарелых женщин (45%), для людей с неполным средним образованием (50 %), и тех, кто не удовлетворен состоянием здравоохранения (41%).

31 % опрошенных сказали, что они не будут доверять специалистам в подобных лечебных учреждениях, что характерно и для городских и для сельских жителей. 13 % беспокоятся по причине отсутствия официального контроля за такими лечебными учреждениями, особенно граждане моложе 35 лет (212%) и жители Дальневосточного региона (17%). Только 8 процентов тех, кто не собирается посещать частные, коммерческие лечебные учреждения , беспокоятся по поводу качества, в основном - молодые мужчины (13%) и люди с низким уровнем образования.

Затем респондентов попросили выбрать одну из двух точек зрения на приватизацию и ее влиянии на российскую систему здравоохранения. Только 52 % опрошенных имеют негативное отношение к ситуации и согласны с точкой зрения, что "управление здравоохранением частными лицами и бизнесменами сделает здравоохранение недоступным для большинства россиян и позволит этим людям обогатиться на несчастьях других".

Только 23 % имеет положительное отношение к приватизации, поддерживая мнение, что "если частные лица и бизнесмены будут управлять российскими больницами и аптеками, это заставит больницы внимательнее относиться к нуждам пациентов и докажет неэффективность лечебных учреждений, подчиняющихся государственным органам". Еще 19 % считают, что обе точки зрения правомерны, и 7 % не уверены в ответе.

Точка зрения, что частное управление системой здравоохранения подтолкнет развитие конкуренции и улучшит систему, поддерживается теми респондентами,

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кто поддерживает идею реформ: 18-34 года (32 % поддерживают идею улучшения, 40 % возражают), с высшим образованием (35%/43%), работники частного сектора (40%/35%), те, кто не удовлетворен системой (27%/49%).

На Дальнем Востоке идее частного здравоохранения оказывается больше поддержки, чем в других областях (36%/41%). Эта поддержка слабее в южных, центральных и северных областях (соответственно, 51 и 56%). Респонденты в этих областях считают, что частная система здравоохранения будет недоступна большинству россиян.

Кроме того, сильное противодействие этой идее возникает среди респондентов более старшего возраста (65 % тех, кто не поддерживает эту идею), и россиян с низким (58 %).

ВОЗМОЖНОСТИ РЕФОРМ

Потребители услуг российского здравоохранения были разделены на группы, в зависимости от их мнения о российском здравоохранении, в целом, и их уверенности в том, что врачи отвечают их потребностям. Основываясь на утверждении того, что граждане, не удовлетворенные существующей системой здравоохранения, могут поддержать некоторые реформы и отнестись к ним положительно, эти группы разделены на следующие категории:

Удовлетворены существующей системой/
Противники реформ 11 %

* Центральная/Северная Россия
* Городские жители (не самые крупные города)
* 65 лет и более
* Женщины старше 45 лет
* Пенсионеры
* Отрицательное отношение усиливается по мере уменьшения уровня образования

* Отрицательное отношение усиливается по мере уменьшения уровня доходов
* Главное значение придается бесплатности медицины

Не удовлетворены системой/

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Положительно относятся к реформам	46 %

* Урал, Сибирь и Дальний Восток
* Города с населением менее 10 000 человек
* 18-34 года
* Женщины моложе 45 лет
* Семьи с детьми
* Имеющие средне-техническое или высшее образование
* Служащие
* Считающие, что проблемы здравоохранения временны
* Обращались за платной и бесплатной медицинской помощью за последние два года

Нейтральны	2 %
Другие мнения	41 %

Подобный вывод напрашивается при анализе ответов различных групп населения на вопрос о желании воспользоваться услугами коммерческого или некоммерческого медицинского учреждения. Из тех, кто удовлетворен состоянием здравоохранения, менее половины (44%) отвечают, что они обратятся в лечебное учреждение, контролируемое "медицинским трастом", т.е. некоммерческое. Однако, среди тех, кто не удовлетворен системой здравоохранения, этот показатель увеличивается до 58 %. Что касается коммерческих, частных лечебных учреждений, процесс респондентов, которые удовлетворены состоянием системы и готовы обратиться в такое учреждение, составляет 49 %, среди неудовлетворенных системой респондентов процент составляет 56.

Понятно, что у респондентов, относящихся положительно к идее реформ, существуют определенные опасения, которые придется преодолевать, но данные обнадеживают. Например, 60 % респондентов, удовлетворенных состоянием здравоохранения и противящихся реформам, заявляют, что частное здравоохранение будет недоступно большинству россиян, и 49% неудовлетворенных респондентов согласны с идеей приватизации медицинских учреждений и 27 % уверены, что это поможет улучшить положение. В категории респондентов, неудовлетворенных системой, процент тех, кто считает, что проблемы российского здравоохранения временны, на 24 пункта ниже (соответственно, 50 % и 74 %). Эта категория также меньше значения придает сохранению бесплатности медицинской помощи и более позитивно относится к идее оплаты некоторых дополнительных медицинских услуг.

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Однако, необходимо очень осторожно использовать данные по отношению к приватизации медицинских учреждений. При обсуждении процесса приватизации группа респондентов, которые не удовлетворены состоянием системы, относится к данной идее позитивно. Но сам термин "приватизация" вызывает негативную реакцию. Тогда как 39 % респондентов, вполне удовлетворенных системой заявляют, что "приватизация - это всегда плохо", это утверждение поддерживают 47 % респондентов из второй группы. Большой процент респондентов на Урале и в Сибири негативно относятся и к существующему здравоохранению, и к идее приватизации.

ПОБУЖДАЮЩИЕ МОТИВЫ

В последней части опросов обсуждались некоторые утверждения, касающиеся здравоохранения, с тем, чтобы проверить отношение общественности к некоторым проблемам. Следующая таблица проиллюстрирует результаты:

УТВЕРЖДЕНИЕ	СОГЛАСНЫ	НЕ СОГЛАСНЫ
Западные фармацевтические компании эксплуатируют россиян и им необходимо поставить барьер	42%	45%
Российская система должна быть всеобщей	58%	33%
Я лучше, чем врачи, могу позаботиться о себе	23%	70%
Необходимо заменить устаревшее оборудование	94%	2%
Приватизация всегда плоха	45%	22%
Российские врачи лучше западных, потому что они не имели современных лекарств и дорогого оборудования	59%	20%

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Ясно, что самую сильную поддержку получило утверждение о необходимости заменить устаревшее оборудование в медицинских учреждениях (94 % опрошенных). Вспомним, что респонденты считали также это утверждение главной проблемой, над которой должно работать Правительство (вопрос 34).

Наблюдается некоторое замешательство при реакции на утверждение, что западные компании просто эксплуатируют россиян, используя ситуацию, и зарабатывают деньги на несчастьях людей. Эту идею поддержали, в основном, люди пожилого возраста (49 %), рабочие (47 %), респонденты с низким уровнем доходов (48 %) и те, кто считает, что система здравоохранения ухудшится (48 %).

Мнение о том, что российское здравоохранение должно быть всеобщим, зависит, в основном, от возраста респондентов. Те, кому меньше 35 лет, в основном, не согласны с этим утверждением (43% согласны/47% не согласны), тогда как процент поддержки этой идеи увеличивается с возрастом опрашиваемых. 64 % в категории 45-54 года, 71 % - среди тех, кому 55-64 года, и 75% тех, кто старше, поддерживают это утверждение.

Однако, наиболее важным результатом можно считать то, что 45 % граждан считают, что приватизация принесет вред. Это доминирующий взгляд на вещи и среди городского населения (52 % жителей в городах с населением более 500 000), и среди жителей Уральско-Сибирского региона (51%), среди тех, кому 45-54 года (54 %), среди рабочих (50%), и среди тех, кто утверждает, что система здравоохранения ухудшится в ближайшие десять лет (53 %). Как уже было упомянуто, зарегистрировано и большое количество респондентов, неудовлетворенных существующей системой и положительно относящихся к реформам, и одновременно отвергающих идею приватизации (47 %).

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HEALTH CARE IN RUSSIA: PROVIDER VIEWS

The men and women employed in the Russian health care field are being faced with an evolution in their entire environment. They know that the system that they were trained for and that they worked in for most of their careers is not keeping pace with the demands being pressed upon it. While they are quite open to change as a general theme and often agree with many precepts of reform, when asked for solutions to the problems they cite, providers generally hark back to old ideas that they are familiar with (more assistance for the state) or resort to self-preservation (higher salaries).

A number of different groups were interviewed that we will refer to as health care "providers." Over half (52%) of those interviewed are practicing doctors, while 12% are administrators of polyclinics or hospitals. Twenty percent (20%) are nurses, 6% are medical attendants and about one-in-ten are pharmacists or in the pharmaceutical industry. Notably, there are some glaring gaps in the providers', including the polyclinic or hospital administrators,' knowledge of how their own facilities operate as one will see, and many major decisions appear to be still left up to a centralized bureaucracy.

VIEWS ON THE STATE OF HEALTH CARE

A majority (55%) of health care providers indicate that they are not satisfied with the current state of health care in Russia, while 45% support the converse view. This exactly matches the views of the population as a whole. Negative evaluations of the system are much more likely to come from providers in the Far East (83% not satisfied) and Southern Russia (59%) regions of the country. Doctors and administrators also tend to be much more negative (58% and 59% not satisfied, respectively) than such groups as medical technicians (35%) or pharmacists (46%).

While there is little difference between rural and urban providers, those who work in larger facilities tend to be more negative than their counterparts employed in smaller environments. While just 45% of those who work in a facility with less than 50 employees are dissatisfied with the state of health care in Russia, this jumps over 15 points among those in facilities with over 50 employees (64%).

Women employed in the health care field tend to be much more negative in their evaluation of Russia's health care system. While fifty-seven percent (57%) of female providers indicate that they are not satisfied with the state of medical care in the country, only 49% of male providers say the same. Notably, unlike with the general population, age is not a major determinant of attitudes on this issue, with older providers just as negative as their younger counterparts. Likewise, income is also not a strong determinant of provider attitudes as it was with consumers.

Those who are not satisfied with the current state of health care, were then queried as to who is at fault. Forty-one percent (41%) of those who indicate that they are dissatisfied with the system blame "reformers in the government today." Older health care providers are much more likely to focus on the reformers as the cause of the system's woes, with only

one-quarter (26%) of those under the age of 35 citing the reformers, but 38% of 35-44 year olds, 52% of 45-64 year olds and fully 71% of those over the age of 55 blaming this group. Administrators (58%), those in large facilities (54%), male respondents (60%) and those in Southern Russia (51%) also are driving the focus to reformers. Notably, those in urban areas (44%) tend to blame the reformers more than their counterparts in rural areas (33%).

Twenty-two percent (22%) of providers focus on the Ministry of Health. Nurses, medical attendants and pharmacists who are not satisfied with the state of health care are much more likely to focus on the Ministry of Health as the guilty party, with over 30% of each of these groups placing the blame with them. The Ministry of Health is also much more likely to come under fire from those in the Far East region (40%), working polyclinics that are attached to enterprises (45%) or in small hospitals (25%), under the age of 35 (36%), or receive additional income from patients (42%).

Only 15% cite the old Soviet system as being to blame for the current state of health care in Russia. Those in cities with a population of 100,000 or more (23%), practicing doctors (20%), those employed in polyclinics (20%) and respondents who do not receive additional income (17%) tend to point at the old system as most to blame.

Respondents who are not satisfied with the state of health care today were then queried further as to the specific reasons that they are not completely satisfied and then asked to explain how they would correct it. Unfortunately, as was mentioned earlier, the responses were rather simplistic. Thirty-nine percent (39%) view the situation as a result of a lack of finances, and the most commonly cited solution is to increase state funding (29%). Only six percent (6%) name having people pay as the best solution, while 5% identify changing the system as a whole and a mere 1% name encouraging privatization. *An amazing 45% of the providers who are dissatisfied with the state of health care in Russia cannot think of any way to solve or alleviate the problems they are faced with on a daily basis.* Only 12% can think of more than one solution.

Other commonly cited reasons that providers are not satisfied with the state of medical care are the lack of medicines (6%) and equipment (2%), the management of the facilities being poor or not the right entity (7%), the problems of the country as a whole impinging on the situation (5%), along with low salaries and poor working conditions (4%). Only 1% indicate that people cannot afford to pay for care, and another 1% regard the quality of services as poor.

An overwhelming seventy-eight percent (78%) of the health care providers indicate that they feel less secure today about the health care system as compared to ten years ago. Only seven percent (7%) say they are more secure (mostly administrators), while 13% regard things as about the same.

Insecurity about the system is highest among those away from Moscow. Eighty-seven percent (87%) of respondents in the Southern Russia region, as well as 83% of those in the Far East and 79% of those in the Ural/Siberia area feel less secure about the system than ten years ago. Concern drops to 68% in the Central/North Russia region.

Medical attendants and pharmacists tend to be much less secure than other providers.

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Older respondents also exhibit more concern, with 88% of those over the age of 55 regarding things as less secure (compared to less than 80% of those under the age of 55).

QUALITY OF CARE

The health care providers were also asked to evaluate the level of competency of the staff of hospitals/polyclinics and apetkas in their area. Most of the respondents did not rate their compatriots very well. Sixty percent (60%) regard the staffs of hospitals and polyclinics and 50% of apetka employees as only being "generally competent but most could use major training." Less than 5% thought either institutions' employees were "very well trained in the latest medical technologies."

Hospitals/Polyclinics: Just 4% of the providers indicate that the staff of these institutions are very well-trained, and 21% instead think that they are "well-trained but many could use some additional training in certain areas." Administrators and those in the largest cities are more likely to take the most positive view of the hospital and polyclinic staff. As mentioned above, 60% consider them just competent, which is the dominant view of all key groups and in every region of the country. Only 12% think the area staff are generally incompetent, driven by those in Southern Russia (20%), practicing doctors (15%) or pharmacists (14%).

Apetkas: Providers are less sure about the capabilities of pharmacists and apetka employees (16% unsure), but generally the numbers do not move much. A mere 2% indicate that they are very well-trained, while one-quarter say they are well-trained but need additional training. This view is most likely to be held by the pharmacists themselves and those in large facilities. Approximately half (49%) consider them to be competent but in need of major training, while 8% say they are incompetent. The latter view is most likely to come from practicing doctors, providers in rural areas and those employed in polyclinics.

Respondents were also queried about the availability of medicine over the last six months to a year. Health care providers tend to be slightly more negative in their assessment of this situation than the population as a whole. While a majority (52%) of providers say that availability of drugs and medicine has gotten worse, it drops to 41% of health care consumers that say the same. There tends to be more of a scarcity for providers in rural areas (58% gotten worse) and in the Far East (75%). Notably, providers employed in hospitals (61%) appear to be having more shortages than those in polyclinics (49%) or apetkas, who actually say the situation is getting better (53%) rather than worse (37%).

Notably, the larger the facility the more likely that providers report medicine to be less available, as 56% of providers employed in facilities with more than 200 employees indicate that the supply of medicine has gotten worse. However, among those with 50-200 employees, only 47% indicate the shortages have gotten worse, while in facilities with less than 50 employees, the providers are actually more likely to indicate that things are getting better (46%) than worse (43%).

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NEW INSURANCE LAWS

Awareness of the new insurance law passed last year is quite high among health care providers (88%) over 25 points higher than with the general population (61%). Awareness tends to be highest among administrators (97%) and practicing doctors (92%), dropping among nurses (80%), medical technicians (82%) and pharmacists (75%). Awareness also tends to increase with the size of the facility, whether it be a hospital or polyclinic. One should note that those who are not satisfied with the present state of health care appear to be paying somewhat closer attention to new changes (90% aware), compared to those who are satisfied (85%).

While there is a high level of awareness among those employed in the health care field, they are extremely divided over what impact this new law will have. Twenty-nine percent (29%) of those who have heard of the law believe it will improve the situation (compared to 38% of consumers who have heard of the law). One-third (33%) of the providers state that the insurance law will make things worse (just 10% of consumers), and less than one-quarter (23%) say it will have little impact (26% of consumers).

Rural providers appear to be the most optimistic about the new law's impact on the system, with 38% indicating it will improve things, compared to 26% of those in urban areas. The Central/Northern Russia region is the only geographic region where providers are more likely to have a positive view of the law than a negative (38%+, 28%-). Southern Russia is the most negative area of the country, as fully forty-three percent (43%) think that the law will make the system worse (only 30% better).

Medical attendants and pharmacists are the only groups more likely to view the new law positively than negatively, although administrators are virtually evenly divided (32% each). Both doctors and nurses tend to believe the law will have a negative impact (34% and 36%, respectively) rather than a positive impact (28% and 27%).

Respondents employed in polyclinics also tend to be more negative (26% improve, 33% worse) than their counterparts at hospitals or apetkas. Negativity is especially strong at polyclinics which are not attached to a business enterprise, with 26% saying the law will be an improvement but fully 38% believing that it will make things worse.

The key determinant, however, on this issue is satisfaction with the system as it is right now. Among those who are satisfied, thirty-four percent (34%) think that the new insurance law will improve the system (28% worse). However, only 25% of those who are presently dissatisfied with Russia's health care think the insurance law will improve things, and fully 37% indicate it will cause further deterioration in health care. The negativity is especially potent among those who blame reformers for the system's current woes, as 46% of these respondents believe the insurance law will just make things worse.

Health care providers across the country are also mixed in their opinion of *how much* impact the insurance reform law will have on their job and others in their profession. Only twenty-one percent (21%) of the respondents believe that the new law will have a major impact on their job and others like them, mostly driven by those in hospitals (25%), doctors (25%) and those in larger facilities (27%). Thirty-one percent (31%) of the providers,

however, counter that the reform laws will only have a minor impact, an opinion notable among administrators (52%), providers in rural areas (45%), men (40%) and those who are satisfied with the present system (37%). Another thirty-one percent (31%) believe that the law will have no impact at all, a view more likely to be espoused in urban areas (36%) compared to just 16% in rural areas, medical attendants (43%), and those in smaller facilities (40%).

PRIVATELY PAID SERVICES

Over three-fourths (76%) of the health care providers state that they do not receive any additional income from patients, while twelve percent (12%) indicate that they do. However, another 12% refused to divulge whether they had additional sources of income, so the practice could be as high as 24%.

The practice is much more common in urban areas, increasing with the size of the city as one can see in the diagram below:

POPULATION	ADDITIONAL INCOME
500,001 +	22%
100,001 - 500,000	18%
50,001 - 100,000	12%
10,000 - 50,000	3%
less than 10,000	7%

Eighteen percent (18%) of doctors and sixteen percent (16%) of administrators report receiving some of their income from privately paid services. Only 5% of nurses and 4% of pharmacists indicate that they ever receive additional income. Providers in smaller facilities also tend to admit to the practice more often (17%) than their counterparts in larger institutions.

Respondents were also queried as to what procedures and treatments should be the government's responsibility to pay for in a basic care package and what patients should be willing to pay extra for. As seen in the next diagram, psychiatric care and prescriptions/medicine for children have a wide mandate from the providers to continue government sponsorship of these programs. Preventative exams are fairly well viewed as necessary to be covered as basic care, with much higher support in urban areas (76%) as compared to rural areas (55%) and with practicing nurses (84%) and medical attendants (88%).

	GOVERNMENT	PATIENT	UNSURE
Psychiatric care/therapy	97%	2%	1%
Abortions	25%	72%	3%
Contraceptives/family planning	32%	66%	2%
Alcohol abuse treatment	34%	60%	6%
Preventative examinations	71%	26%	3%
Prescriptions/medicine for children	98%	1%	1%
Eyeglasses/optometric exam	38%	61%	2%

On the other hand, abortion, family planning/contraceptives, and optometric care are widely seen as being the responsibility of the patient. The view that abortion costs should be paid for by the patient is the dominant view in every region of the country, especially in the rural areas where 83% of the health care providers believe the patient should bear these costs. This is fifteen points higher than among urban providers (68%), who still overwhelmingly support this view. Female health care providers are about ten points more likely to suggest that the state should pay (28%) than their male counterparts (18%).

Similarly, family planning costs tend to be relegated to the individual more so in rural areas (77% patient) than in urban areas (62%). There is no gender-based difference on this issue.

Notably, treatment for alcohol abuse continues to be seen as the responsibility of the patient, with six-in-ten providers believing the patient should pay for this assistance. However, in rural areas there is much more support for state assistance, as 42% suggest the government should cover this treatment while 55% believe the patient should pay. This contrasts with urban areas, where just 31% think it is the state's responsibility and 62% say this falls in the patient's realm. Notably, respondents in the Far East region of the country are evenly divided in this case (50% each), with Southern Russia exhibiting the next highest support for state coverage for alcohol abuse treatment (38%).

PUBLIC HEALTH EDUCATION

A majority of health care providers in the country indicate that they have assisted in some capacity in government public health education efforts. Participation rates tend to be much higher among doctors (61%) and administrators (81%) than it is with nurses (34%) or pharmacists (29%). It also tends to be more common in the biggest cities (69%) and in the Far East region (67%) of the country. Notably, Central/Northern Russia providers are the least likely to indicate that they have been involved with a government public education program.

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Polyclinics also appear to be more participatory in these programs, with 58% of providers employed in these facilities having worked on such a campaign. This is especially tue of polyclinics attached to a business enterprise (81%) as opposed to those which are not (49%).

Providers who receive part of their income from privately paid services are also more likely to be involved in these programs (65%) than those who are solely paid by salary (54%).

The issue that most health care providers who have been involved in a government public health education campaign cite is the anti-smoking and drinking initiative (87%). Approximately four-in-ten providers who have been involved work on women's health issues, (44%), elderly care (40%), catastrophic care (40%) and childrens' health issues (39%).

INCENTIVES REFORM

An overwhelming 78% of Russian health care providers state that the current health care system does not adequately meet the needs of the Russian people. This is the dominant view in every region of the nation and with every single key subgroup of providers.

However, the remedies that the providers offer to make the system better tend to be rather centered around old solutions and their own needs. Nearly half (49%) of the providers say that increasing salaries is the incentive that "should be available to health providers and the bureaucratic system to allow them to better respond to the needs of the Russia people." Similarly, the second most cited response is to increase state funding (13%).

Some respondents clearly are unable to grasp the concept of a true incentive. They suggest adding more modern equipment as an incentive to better serve the people (8%) or providing them with medicine and drugs (5%). While these would definitely be beneficial, they do not really make the providers <u>want</u> to improve the quality of the care in other ways.

Only 1% of the providers suggest encouraging private activity, while just 3% think an appropriate incentive is allowing self-administration of facilities. Only one percent (1%) focus on improving the prestige of the profession as an incentive to draw in better people and therefore improve care.

However, a majority (69%) of the providers indicate that "having competition among health care providers, such as hospitals, polyclinics, pharmacies and pharmaceutical manufacturers, would result in better care at lower costs" - the whole concept a basic precept of capitalism and free trade. Less than one-quarter (24%) disagree with this idea.

Support for competition in the health care field is near or over 60% in every region of the country and a majority of every key subgroup agrees with the concept of using competition to lower costs and improve quality. The most support tends to come from providers in the Ural/Siberia (78%) and Far East regions (88%). Administrators (84%), pharmacists (82%) and chief nurses (80%) also tend to be much more supportive of competition, than practicing doctors or practicing nurses (63% and 58%, respectively). Providers who already receive some of their income from privately paid services are more likely to agree with a pro-competition stance (85%) than their counterparts who only receive salary (65%).

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However, fully three-quarters (74%) of the Russian providers favor formally allowing patients to pay doctors and nurses extra payments for certain treatments or in certain facilities, with nearly half (48%) favoring this strongly. Again, less than one-quarter (23%) oppose formalization of this process.

This is the dominant view in every region of the country and with every key subgroup. One should note that there is virtually no difference in the views of doctors and nurses, versus administrators and other providers.

DECISION-MAKING AUTHORITY

	DOES	DOES NOT
Hiring of personnel	88%	11%
Setting salaries and conditions of employment	32%	66%
Purchasing equipment	66%	27%
Choosing the brand of equipment	64%	27%
Deciding which patients to accept	66%	30%
Deciding which procedures and specialties to offer	56%	39%
Renting space or selling goods to third parties	35%	53%
Firing personnel	89%	10%
Allocation of funds earned through private patients or patients outside of the local area	40%	34%
Buying medicines	75%	21%
Choosing the chief doctor	19%	72%
Deciding treatment regime and length of stay	59%	30%

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As one can see in the previous diagram, there are a number of basic decisions that continue to be controlled by an outside bureaucracy or government agency, instead of the individual hospital or polyclinic. Clearly, each facility has the most authority to handle the hiring and firing of its personnel, as nearly 90% of the providers respond positively that this aspect of the management of the facility is handled internally.

Conversely, there are a number of decisions that are widely made outside the facility. Just 19% of the doctors, nurses and administrators indicate that choosing the chief doctor is an internal decision, and just 32% set salaries and conditions of employment internally. Only 35% of these providers can decide whether to rent space or sell goods to third parties, mostly urban and smaller facilities.

Overall, it appears that urban facilities generally have more leeway and freedom to make their own decisions than facilities in more rural environments. Similarly, very large and very small facilities tend to be left more on their own, while medium size facilities (50-200 employees) are more likely to have more decisions made externally.

When asked, which of these decisions, they would most like to have made internally rather than by someone else, providers' minds again turn inward. Forty-five percent (45%) indicate that they would most want the setting of salaries and employment guidelines to be made within the facility, a desire more likely to be expressed by rural providers (59%) rather than urban (40%), and nurses (64%). Fourteen percent (14%) would prefer to have the ability to choose the chief doctor, mostly practicing doctors (17%) and medical attendants (18%). Another 7% want to be able to purchase equipment on their own, especially those in polyclinics and practicing doctors.

Administrators only were asked a few additional aspects of the management process and whether they personally were able to make these decisions. These results are illustrated in the following chart:

	DOES	DOES NOT
Allocate budget of hospital/clinic	55%	45%
Borrow money (for example, to purchase equipment/supplies)	39%	59%
Build new extensions to the facility	40%	57%
Renovate facility	72%	28%
Change type of procedures offered	61%	39%
Change reimbursement system	48%	52%

The only management decision that is overwhelmingly left up to the hospital or polyclinic administrators is the renovation of the facility, although they are generally not allowed to build new extension to the facility.

The most interesting data comes on the issue of changing the reimbursement system, as almost half (48%) of the administrators indicate that they already have this power. This issue is also the most important aspect of the management of the facility that the administrators who do not now control this would like to have the authority to do. Ability to change the reimbursement system increases to 68% of administrators in Central/Northern Russia and 57% of those in urban areas. Half (51%) of those in polyclinics are able to make this decision, while just 35% of those in hospitals can change their reimbursement system. Smaller facilities appear to be able to make this decision more than their larger counterparts.

In addition, most of these same subgroups of administrators are able to allocate their budget themselves. Sixty-eight percent (68%) of those in the Central/Northern region, 61% of urban respondents and 62% of polyclinic administrators are able to allocate their budget for the facility.

One should note that in almost every case, the administrators who are able to make more of their own decisions about the management of their facility are more likely to be sympathetic to reform and to place the blame for the system's current woes on the old Soviet system. Conversely, those who do not have the authority to make these decisions tend to blame the reformers for the system's problems and be more resistant to reform.

CURRENT FINANCIAL SYSTEMS

The first thing to point out is how ignorant of this aspect of their facility most health care providers are in general. On some issues, a majority of the providers are not capable of even estimating or guessing about that aspect of their facility's finances.

A plurality of the health care providers interviewed are employed at facilities that directly receive their funding from the state health authority (39%), while 14% receive their funding from the Ministry of Health. Just 3% say that their funding comes solely from insurance, and only 5% identify themselves as privately financed. Six percent (6%) are funded through enterprises, while 3% identify none of these and 11% are unsure.

Several facilities are funded by more than one means, with thirteen percent (13%) indicating that their funding comes from both the state and insurance, while 5% receive funding from the state, insurance and private payments. These facilities are more likely to be in Southern Russia, and the Far East regions of the country.

Those who receive their funding from the state health authority alone are more likely to be rural (51%), as opposed to urban (35%), and be a hospital (50%) instead of a polyclinic (35%). About 65% of the providers in the Central/North Russia area note that their funding comes from either the state health authority or the Ministry of Health. None of the providers in this region indicate that their funds come from insurance alone.

Solely private funding appears to be only in more urban areas (7%) and limited to polyclinics (7%). These facilities also tend to be small with less than 50 employees (14%).

Facilities which rely on a combination of the state and insurance for their funding are more likely to be in Southern Russia (22%) and the Far East region of the country (21%). There does not seem to be a major correlation between the size of the facility and whether it receives funding from both the state and insurance. Polyclinics (13%) and hospitals (14%) appear to make up about the same amount of funding from this system.

Large polyclinics appear to make up the bulk of those facilities which receive funding from the state, insurance and private sources.

Among those providers who indicate that some of their facility's funding comes from insurance, a majority (55%) have no idea how much of it comes from this source. Twenty-eight percent (28%) note that less than 30% of their income is derived from this source, while 17% say that more than 30% can be traced to insurance.

Facilities who rely most heavily on insurance tend to be in the Ural/Siberia and Far East regions of the country. Polyclinics are more likely to have a bigger portion of their budget coming from insurance (19%) than hospitals (12%). These facilities also tend to be medium-sized facilities (38%).

Providers are also quite ignorant of the type of reimbursement system employed by their facility. Just under half (50%) of polyclinic employees are able to tell how they receive reimbursement for their services, while only 40% of hospital employees are able to explain their reimbursement system.

Of polyclinic employees, thirty-four percent (34%) simply have a fixed salary, while just 4% are reimbursed on a per procedure basis with 7% on a per patient basis and 4% a combination of the two.

Among hospital employees, 27% indicate that they have a negotiated budget, while 5% say it is per patient, 3% per bed and only 1% by the length of the stay for a patient.

As most of the providers do not know how they are being financed right now, it is not surprising that it is difficult for them to predict what impact a solely insurance-based system would have on their facility. Forty-two percent (42%) are unsure what impact this would have on them, while two-in-ten providers indicate that this would make things better, while 28% say it would have a negative impact. Another eleven percent (11%) think the effect would be negligible.

There is a definite geographic-based difference in attitudes on this issue. While one-quarter (25%) of rural respondents assert that an insurance system would improve the health care system, agreement drops 7 points to 18% of rural providers. In fact, providers in the Ural/Siberia region of the country are the most likely to feel that this would improve things, dropping to 19% of those in Southern Russia and less than 13% of respondents in either the Far East or Central/North Russia regions.

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While there is no difference between hospitals and polyclinics on this issue, a positive assessment of insurance's impact on the system does depend on the size of the facility one works in, with those in larger facilities more likely to be positive about this reform (28%). Twenty-one percent (21%) of providers in medium-sized facilities think insurance would have a positive effect, while just 16% of those in smaller facilities say the same.

Respondents who receive some of their income from privately paid services and those in the highest income bracket are also more positive about the impact of an insurance-based system. Respondents who blame the old Soviet system for the health care system's present woes are also more likely to look on this issue positively.

POTENTIAL REFORM SYSTEMS

Insurance-Based System

Respondents were also queried about some health care system models employed in other nations and the feasibility of utilizing such a system in Russia. The first hypothetical system was described as follows: "In some countries, such as France, Germany and the Netherlands, the government pays for health care by contributing to insurance companies, instead of contributing directly to the providers of the services, like hospitals and polyclinics. The providers are private and can make all their own decisions." Fully fifty-seven percent (57%) of the providers indicate that they would support instituting such a system in Russia, while only 22% are opposed at this time.

There is a five point gap between rural and urban respondents in their support for this type of a system, with sixty-one percent (61%) of rural providers favoring institution of such a system while 56% of urban providers say the same. Support for reform tends to be much stronger in the Far East (67%) and Ural/Siberia regions (64%), dropping somewhat in the Central/Northern Russia region (58%). The Southern Russia regions is the only area of the country where support for this system drops below the 50% mark (48%).

Polyclinic employees also tend to be more open to reform (60%), than their counterparts in hospitals (53%) or apetkas (57%). This is especially true of polyclinics which are attached to an enterprise (69%).

Similar to the general population as a whole, support for a reformed health care system among providers is also dependent on age, with resistance increasing among older respondents. Fully sixty-eight percent (68%) of providers under the age of 35 are in favor of instituting an insurance-based system, dropping to 61% of 35-44 year olds. Support falls further among 45-54 year olds (48%) and with those over the age of 55 (35%).

Notably, satisfaction with the present system has no impact on support for a new type of system, as 58% of those who say that they are satisfied and 57% of those who are not satisfied are in favor of instituting this new type of system. However, who one blames for the problems of the present system does impact on support for reform, with fully 87% of

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those who blame the Soviet system supporting reform but only 48% of those who blame the reformers wanting to change the present system.

Of those who agree with the precept that competition in the health care system fosters better care at lower costs, sixty-three percent (63%) are in favor of instituting a new system like the one in France and Germany. Only 47% of those who do not agree with this idea favor a system like this in Russia.

However, respondents are not quite as confident of the effect that such a new system might have on their own facility. Thirty-eight percent (38%) of the providers think that under a system where their "facility is private and can make its own decisions but receives no direct funding from the state" that their facility could provide better care than it does now. However, one-quarter (25%) of the providers think that this would have no impact on their facility's performance and 18% actually say the quality of care would deteriorate.

The most optimistic assessments of the impact of a system with indirect government funding and private management of facilities come from providers in the Far East (63% better care) and Ural/Siberia regions (42%), as compared to those in Southern Russia (39%) and the Central/Northern region (28%). Although overall, rural providers are more positive in their assessment of the new system's impact on their facility's care (42% better as compares to 36% of urban), the respondents in the largest cities with populations of over 500,000 are extremely positive with 45% indicating that such reform would improve the care that they give.

Administrators are the most likely to say that this would be a positive step for their own facility (50%), with doctors (40%) and pharmacists (39%) also fairly positive. Nurses and medical attendants appear to be the most resistant to such a change with just 29% and 24%, respectively, thinking that things in their facility would improve under this new system.

A majority of the providers do predict increasing costs under a system modeled after the French and Germans. Sixty-four percent (64%) of providers, increasing to 75% of rural providers, foresee higher costs as a result of this new system, while only 4% believe costs would decline. Eleven percent (11%) forecast that prices would remain about the same, although another 22% are uncertain of the system's impact on costs.

Health Trust System

Respondents were then described a system employing health trusts as follows: "in some countries, such as Great Britain, Sweden, Denmark and Finland, the government owns hospitals and clinics, but the facilities operate themselves and control all decisions. The state pays the facilities on a per capita basis or by negotiating contracts each year." Support for this type of system increases to an impressive seventy-eight percent (78%), with fully four-in-ten providers supporting this strongly. A mere seven percent (7%) oppose this new type of system, while another 15% are unsure right now.

Support is highest in the Central/Northern and Far East regions, where 84% and 83%, respectively, favor institu[illegible]

Southern Russia and 68% in the Ural/Siberia region. Overall, rural providers exhibit six points more support for a system modeled after the British than their urban counterparts (82% to 76%).

Support is widespread with employees of both polyclinics and hospitals, but is especially high among employees of polyclinics attached to businesses (83%) and those with more than 15 doctors in them (86%). Notably, support for this type of system is not affected by age or support for competition within the health care system.

Respondents are much more likely to feel that this type of system would benefit their own facility, as 61% indicate that care would improve under the health trust system, while just 5% say things would get worse. The only substantial negative evaluation comes from providers in the largest cities (12% worse) and hospital employees (10%).

ЗДРАВООХРАНЕНИЕ В РОССИИ: ПОЗИЦИИ МЕДИЦИНСКИХ РАБОТНИКОВ

Мужчины и женщины, занятые в российском здравоохранении, являются свидетелями эволюционных изменений, охвативших всю отрасль. Они осознают, что система, для которой они были подготовлены и в рамках которой прошла большая часть их служебной карьеры, не удовлетворяет требованиям, предъявляемым к ней. Хотя они, как правило, открыты для реформ и нередко согласны со многими положениями реформирования, однако, на вопрос,что бы они предложили в качестве решения для проблем, ими называемых, медики обычно прибегают к старым хорошо известным идеям ("больше помощи для гос.сектора") или же заботятся о самосохранении (повышение зарплаты).

Было опрошено несколько групп людей, которых мы будем называть "медиками". Более половины опрошеных (52%) являются практикующими врачами, тогда как 12% принадлежат к администрации поликлиник и больниц. 20% составляют медсестры, 6% - младший медицинский персонал, и примерно каждый десятый является фармацевтом или связан с фармацевтикой. Примечательно, что существует несколько явных расхождений во мнениях среди медиков, включая администрацию больниц и поликлиник, по поводу того, как функционируют их медицинские учреждения, в чем читатель убедится впоследствии, а многие ключевые решения, видимо, до сих пор являются прерогативой центральных бюрократических структур.

ВЗГЛЯДЫ НА СОСТОЯНИЕ ЗДРАВООХРАНЕНИЯ

Большая часть медиков (55%) выразили свою неудовлетворенность существующим состоянием российского здравоохранения, тогда как 45% придерживаются противоположного мнения. Это соотношение точно соответствует настроениям всего населения. Негативные оценки более присущи медикам Дальнего Востока (83% не удовлетворены) и южных регионов России (59%). Врачи и администрация тоже, в большинстве своем, были настроены более критически (58% и 59%, соответственно), чем такие группы, как медицинские технические работники и фармацевты (46%).

Хотя между медиками в сельских районах и городскими медиками не существует больших различий, те, кто работают в крупных медицинских учреждениях, более склонны к критике, чем их коллеги в не столь крупных учреждениях. В учреждениях со штатом работников менее 50 человек процент недовольных составляет 45%, тогда как в учреждениях, где штат превышает 50 человек, этот показатель выше на 15 пунктов (64%).

Женщины, занятые в здравоохранении, очевидно, более критически настроены в своих оценках российского здравоохранения. 57% женщин-медиков выразили неудовлетворенность состоянием здравоохранения в стране, тогда как среди мужчин-медиков эта цифра равна 49%. Примечательно, что в отличии от

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населения в целом, возраст не влияет на позицию, занимаемую по этому вопросу, т. е. медики в преклонном возрасте оказались не менее критически настроенными, чем их молодые коллеги. Аналогично, уровень дохода не является основным определяющим фактором отношения среди медиков, в противоположность ситуации с потребителями.

Респондентам, которые выразили неудовлетворение существующей ситуацией в здравоохранении, затем был задан вопрос относительно того, кто виноват в этом. 41% из тех, кто не доволен системой, винят "реформаторов в теперешнем правительстве". Старшие по возрасту медики очень склонны настойчиво называть реформаторов виновниками всех бед системы, причем в возрастной группе до 35 лет подобного мнения придерживается лишь четверть (26%), в группе 35-44 лет - 38%, в группе 45-64 лет - 52% и в группе старше 55 лет - 71%. Видят причину в реформаторах и администраторы - 58%, те из них, кто работают в крупных учреждениях - 54%, респонденты-мужчины - 60% и те, кто работают в южных регионах России - 51%. Примечательно, что те, кто работают в городах, более склонны к критике (44%), чем те, кто проживает в сельской местности (33%).

22% медиков видят причину в Министерстве здравоохранения. Медсестры, младший медицинский персонал и фармацевты, недовольные существующей ситуацией в здравоохранении и значительно более склонные винить Министерство здравохранения составляют более 30% в каждой из соответствующих групп. Министерство здравоохранения, с большой вероятностью, оказывается под огнем критики медиков дальневосточного региона (40%), медсанчастей (45%) или же в небольших больницах (25%), среди тех, кому нет еще 35 лет (36%) или же тех, кто имеет дополнительный доход за счет предоставления платных услуг пациентам.

Только 15% видят причину нынешнего состояния здравоохранения России в старой советской системе. Склонны придерживаться такой точки зрения 23% опрошенных медиков в городах с населением от 100тыс. и выше, 20% практикующих врачей, 20% работников поликлиник и 17% респондентов, которые не имеют дополнительного дохода.

Респондентам, не удовлетворенным нынешним состоянием здравоохранения, затем был задан вопрос о конкретных причинах их неудовлетворенности и чтобы они предприняли для исправления положения. К сожалению, как отмечалось ранее, ответы отличались упрощенностью. 39% видят причину сложившейся ситуации в недостаточном финансировании, и наиболее часто в качестве меры по ее улучшению называется увеличение финансирования (29%).Только 6% видят решение в превращении здравоохранения в платное, а 5% считают необходимым изменить всю систему в целом, и лишь 1% называет расширение приватизации. ***Удивительно высокий процент - 45% медиков, выразивших неудовлетворенность состоянием российского здравоохранением, не могли назвать ни одной меры для решения или смягчения проблем, с которыми им приходится ежедневно сталкиваться.***

И лишь 12% могут назвать более одного пути решения проблем.

Другими часто приводимыми причинами неудовлетворенности состоянием

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здравоохранения являются недостаток лекарств (6%) и оборудования (2%), некомпетентное руководство или же несоответствие формы собственности (7%), проблемы всей страны в целом, обуславливающие эту ситуацию в частности (5%), а также низкие заработки и плохие условия работы (4%). Только 1% респондентов указали, что население не в состоянии оплачивать медицинские услуги, и еще 1% считают качество услуг плохим.

Подавляющее большинство (78%) медиков сказали, что сегодня они чувствуют себя менее защищенными с точки зрения медицинской помощи, чем 10 лет назад. Только 7% сказали, что они чувствуют себя более защищенными (главным образом, представители администрации), а 13% считают, что положение мало изменилось.

Наиболее сильно незащищенность ощущается среди медиков, работающих вне Москвы. Менее защищенными, чем 10 лет назад чувствуют себя 87% респондентов на юге России, 83% на Дальнем Востоке, а также 79% на Урале и в Сибири. В центральной и северной России данный показатель ниже - 68%.

Младший медицинский персонал и фармацевты выделяются среди остальных медиков большей незащищенностью.Старшие по возрасту респонденты также проявляют большую озабоченность; так, 88% тех, кому за 55 лет, считают себя теперь менее защищенными, тогда как те, кто моложе 55 лет, составляют менее 80%.

КАЧЕСТВО МЕДИЦИНСКОГО ОБСЛУЖИВАНИЯ

Кроме того, медицинских работников попросили оценить уровень компетентности персонала больниц, поликлиник и аптек в своем регионе. Большинство респондентов невысоко оценили своих соотечественников. 60% считают, что персонал больниц, поликлиник, а 50% считают, что также и аптек, является "в общем и целом компетентен, хотя многие могли бы иметь более солидную подготовку". Менее 5% полагало, что работники больниц, поликлиник и аптек "очень хорошо подготовлены в области новейших медицинских технологий".

Больницы и поликлиники: лишь 4% медицинских работников полагают, что персонал этих медицинских учреждений очень хорошо обучен, и 21% считают, что, хотя они и хорошо обучены, по им стоило бы дополнительно пройти обучение в некоторых областях. Представители администрации и медики из крупных городов более склонны к позитивной оценке персонала больниц и поликлиник. Как говорилось выше, 60% считает их компетентными, и такое мнение превалирует во всех основных группах в любом регионе страны. Только 12% полагают, что местный медицинский персонал большей частью некомпетентен, причем с этим согласно 20% медиков юга России, 15% практикующих врачей, 14% фармацевтов.

Аптеки: медицинские работники высказываются неуверенно по поводу компетентности фармацевтов и аптечных работников (16% неуверены), но в общем

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цифры достаточно стабильны. Лишь 2% высказались в пользу того, что персонал аптек очень хорошо обучен, тогда как четверть сказала, что хотя персонал и хорошо обучен, но нуждается в дополнительном обучении. Это мнение распространено среди самих фармацевтов и в крупных медицинских учреждениях. Примерно половина (49%) полагает, что персонал компетентен, но нуждается в более солидном обучении, а 8% утверждают, что персонал не компетентен. Последняя точка зрения характерна для практикующих врачей,медицинских работников поликлиник и медиков сельских местностей.

Респондентам также был задан вопрос о доступности лекарств за последние 6-12 месяцев. В своих ответах медики были более критически настроенными, чем население в целом. Большинство медиков (52%) утвеждают, что снабжение фармацевтической продукцией стало хуже, тогда как доля населения, пользующаяся медицинскими услугами и утверждающая то же, составляет 41%. Большая нестабильность характеризует ситуацию в сельских районах и на Дальнем Востоке (58% и 75% считают, что снабжение хуже). Примечательно, что больничные работники (61%), очевидно, испытывают большую нехватку, чем медики поликлиник(49%) и аптек, которые говорят даже, что ситуация скорее улучшается(53%), чем ухудшается(37%).

Примечательно, что, чем крупнее учреждение, тем скорее можно ожидать от медиков информации о недостаточном снабжении медикаментами, например, 56% медиков, работающих в учреждениях со штатом более 200 человек, полагают, что снабжение медикаментами ухудшилось. Однако, среди медицинских работников, работающих в учреждениях со штатом 50-200 человек лишь 47% сказали, что нехватка стала более острой, тогда как в учреждениях с числом занятых менее 50 человек медики чаще утверждали, что положение скорее улучшается(46%), чем ухудшается (43%).

НОВЫЕ ЗАКОНЫ О МЕДИЦИНСКОМ СТРАХОВАНИИ

Процент медицинских работников, знающих о новом законе о медицинском страховании, принятом в прошлом году, весьма высок - 88%, что на 25 пунктов выше аналогичного показателя по населению в целом. Лучше всего осведомлены представители администрации (97%) и практикующие врачи (92%), несколько хуже медсестры (80%), младший медперсонал (82%) и фармацевты (75%). Наблюдается тенденция лучшей осведомленности в более крупных учреждениях: поликлиниках и больницах. Надо также заметить, что те, кто недоволен состоянием нынешнего здравоохранения, проявляют несколько больший интерес к последним переменам (90%), чем те, кто удовлетворен (85%).

В то время, как медицинские работники в большинстве своем хорошо знают об этом законе, мнения о его значении сильно расходятся. 29% тех, кто слышал о законе, полагают, что он улучшит ситуацию, по сравнению с 38% потребителей медицинских услуг, слышавших о законе. Треть медиков (33%) утверждает, что закон о мед.страховании приведет к ухудшению (среди потребителей лишь 10%),

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и менее четверти (23%) говорят, что его влияние будет незначительным (26%).

Сельские медики выглядят более оптимистично настроенными относительно влияния закона на систему: 38% считают, что он улучшит ситуацию, тогда как в городах этот показатель равен 26%. Центральная и северная Россия - единственный регион, медики которого придерживаются гораздо более позитивного взгляда на закон (38%+, 28%-). Южная Россия - наиболее критически настроенный регион России, где целых 43% думают, что закон усугубит ситуацию (только 30% считают наоборот).

Младший медицинский персонал и фармацевты образуют единственную группу, относящуюся к закону скорее позитивно, чем негативно, хотя администрация поделена поровну фактически (по 32%). И врачи и медсестры склонны думать, что закон окажет скорее негативное воздействие (34% и 36%, соответственно), чем позитивное (28% и 27%).

Респонденты - работники поликлиник также выглядели более критически настроенными (26% за улучшение, 33% за ухудшение), чем их коллеги в больницах и аптеках. Критическое отношение особенно сильно в обычных поликлиниках, не прикрепленных ни к какому предприятию, в которых 26% ожидают улучшения, а целых 38% - ухудшения.

Главным фактором, определяющим ответ на этот вопрос, является удовлетворенность существующей системой. Среди тех, кто удовлетворен 34% полагают, что новый закон о мед.страховании приведет к позитивным сдвигам (28% думают наоборот). Однако лишь 25% среди тех, кто в настоящее время недоволен системой здравоохранения в России, думают, что закон о медицинском страховании улучшит ситуацию, и целых 37% указывают, что закон усугубит ситуацию в здравоохранении. Критическое отношение особенно явно выступает при опросе тех, кто винит реформаторов в нынешнем бедственном положении системы: 46% таких респондентов выразило уверенность в том, что закон о страховании усугубит положение.

Также медицинские работники страны расходятся во мнении относительно того, насколько сильным будет влияние реформы, связанной с законом о мед.страховании, на их работу и на работу коллег. Лишь 21% респондентов полагает, что новый закон окажет значительное влияние на их работу, причем данная агрегированная величина наиболее обусловлена след. составляющими: 25% - работники больниц, 25% - врачи и 27% - занятые в крупных медицинских учреждениях. Тем не менее, 31% медиков полагают, что законы, предполагающие реформирование, затронут их лишь незначительно - точка зрения, наиболее распространенная среди администрации (52%), сельских медиков (45%), мужчин (40%) и тех, кто доволен существующим положением в системе здравоохранения (37%). Еще 31% считают, что закон не будет иметь вообще никакого влияния - точка зрения, наиболее характерная для городов (36%), в отличии от сельской местности - 16%, для младшего медицинского персонала (43%), для медиков, работающих в небольших мед. учреждениях (40%).

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ПЛАТНЫЕ УСЛУГИ

Более трех четвертей (76%) медицинских работников утверждают, что они абсолютно не имеют никакого дополнительного дохода за счет пациентов, и 12% сказали, что имеют. Однако, еще 12% отказались отвечать на вопрос, есть ли у них дополнительные источники дохода, так что всего эта цифра может быть равна 24%. Платные услуги гораздо более характерны для городов, причем чем крупнее город, тем более распространено это явление, что видно из ниже следующей диаграммы:

Население	Дополнительный доход
500,001 +	22%
100,001 - 500,000	18%
50,001 - 100,000	12%
10,000 - 50,000	3%
менее 10,000	7%

18% врачей и и 16% представителей администрации сообщили, что часть своего дохода они получают за счет платных услуг. Лишь 5% медсестер и 4% фармацевтов указали, что им приходилось когда либо получать допонительный доход. Медики небольших медицинских учреждений, как правило, также признают это чаще (17%), чем их коллеги в более крупных учреждениях.

Респондентам также был задан вопрос о том, какие виды медицинской помощи и процедур должны быть на финансировании правительства как часть базового пакета медицинских услуг и за какие виды медицинской помощи пациенты должны будут платить самостоятельно. Как видно из следующей диаграммы, психиатрическая помощь и рецепты/лекарства для детей рассматриваются подавляющим большинством медиков как услуги, финансирование которых должно осуществляться из правительственных программ. Широко представлено мнение о том, что профилактические осмотры должны быть частью списка основных медицинских услуг, причем в городах такого мнения придерживается 76%, в отличии от сельских районов, где так думает лишь 55%, среди медсестер - 84%, среди младшего медперсонала - 88%.

	Правительство	Пациент	Не уверен
Психиатрическ.помощь/ терапия	97%	2%	1%
Аборты	25%	72%	3%

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Контрацептивы/ Планирование семьи	32%	66%	2%
Лечение от алкоголизма	34%	60%	6%
Профилактические осмотры	71%	26%	3%
Рецепты/Лекарства для детей	98%	1%	1%
Очки/Оптометрический осмотр	38%	61%	2%

С другой стороны, аборт, планирование семьи/контрацептивы и оптометрические услуги рассматриваются в значительной степени как обязанность пациента, причем 6 из 10 медиков считают, что пациент должен платить за эти услуги. Точка зрения, что пациент должен платить за аборт, преобладает во всех регионах страны, особенно в сельской местности, где 83% медиков придерживается этого мнения. Это на 15 пунктов выше, чем в городах, где подавляющее большинство медиков (68%) поддерживает эту точку зрения. Мнение, что государство должно оплачивать эту услугу, распространено более среди женщин-медиков (28%), чем среди их коллег-мужчин (18%).

Подобным образом, затраты по планированию семьи причисляются к услугам, оплачиваемым пациентом, причем чаще в сельской местности (77% пациентов), чем в городах (62%). По этому вопросу нет расхождения, обусловленного различием между полами.

Примечательно, лечение от алкоголизма по прежнему рассматривается как обязанность пациента, причем так считают 6 из 10 медиков. Однако, в сельских районах наблюдается большая настроенность в пользу государственной помощи (42% считает, что государство должно оплачивать эти услуги, а 55% - что пациент). Эти цифры контрастируют с соответствующими цифрами в городах: 31% полагает, что это обязанность государства, а 62% - что это частное дело пациента. Примечательно, что респонденты на Дальнем Востоке оказались поделенными ровно пополам по этому вопросу (по 50%), а юг России выразил наибольшую поддержку точке зрения, предполагающей государственное финансирование лечения от алкоголизма.

СИСТЕМА ГОСУДАРСТВЕННОГО МЕДИЦИНСКОГО СТРАХОВАНИЯ

Большинство медицинских работников страны утверждают, что в той или иной степени они были вовлечены в систему медицинского просвещения. Степень участия врачей (61%) и администрации (81%) значительно выше, чем степень

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участия медсестер (34%) или фармацевтов (29%). Это явление свойственно больше крупным городам (69%) и дальневосточному региону России (67%). Примечательно, что центральная и северная Россия отличается наименьшими показателями участия медиков в государственной системе медицинского просвещения.

Поликлиники принимают более активное участие в обучении: 58% медиков, работающих в поликлиниках, сообщили о своем участии в учебных программах. Этот особенно характерно для медсанчастей, прикрепленных к предприятиям (81%), в противоположность обычным поликлиникам (49%).

Медики, получающие часть своего дохода за счет платных медицинских услуг, также оказывались с большей вероятностью вовлеченными в учебные программы (65%), чем те, которые не имеют иных доходов, кроме зарплаты (54%).

Программами общественного просвещения, наиболее часто называемыми медицинскими работникам, в которых они участвовали, являются антиалкогольная компания и компания против курения (87%). Примерно 4 из 10 медиков, участвующих в программах просвещения, назвали следующие области: женские болезни (44%), уход за престарелыми (40%), оказание неотложной помощи (40%) и уход за детьми (39%).

РЕФОРМЫ, НАПРАВЛЕННЫЕ НА ПОВЫШЕНИЕ ЗАИНТЕРЕСОВАННОСТИ

Подавляющее большинство медиков - 78% - утверждают, что нынешняя система здравоохранения не соответствует потребностям населения России. Это точка зрение общая для всех регионов и для любой подгруппы медиков.

Однако, в качестве мер по оздоровлению предлагаются, главным образом, решения, не отличающиеся новизной, и сводящиеся к защите собственных материальных интересов. Почти половина медицинских работников (49%) говорит, что такой рычаг как повышение зарплат, "должен быть в распоряжении медицинских работников и управленческих структур, с тем чтобы более полно удовлетворялись потребности населения России". Аналогично, вторым наиболее часто даваемым ответом является увеличение государственного финансирования (13%).

Некоторые респонденты явно не могли понять сущности заинтересованности. Они предлагали в качестве стимула улучшить обслуживание оснащение современным оборудованием (8%) или предоставление пациентам лекарственных препаратов (5%). Хотя эти меры, безусловно, будут полезны, но они ни в коей мере не сподвигнут медиков к улучшению качества медицинской помощи в целом.

Лишь один процент медиков предложило развивать частную инициативу, в то время как только 3% видят в введении самоуправления в медицинских учреждениях потенциальный рычаг стимулирования. Лишь 1% подчеркивает важность поднятия профессионального престижа медиков, что привлечет лучшие кадры в эту область и тем самым поправит ситуацию, сложившуюся в

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здравоохранении.

Однако, большинство (69%) медицинских работников выразили мнение, что "конкуренция между разными медицинскими учреждениями, такими как больницы, поликлиники, аптеки и фармацевтические заводы, способствовала бы улучшению качества и снижению цен", что есть концентрированным определением для понятия капитализма и свободной торговли. Менее четверти (24%) выразило несогласие с этой мыслью.

Стимулирование конкуренции в области здравоохранения поддерживается более 60% медиков в любом регионе страны и в любой подгруппе; большинство согласно с мыслью использования конкуренции в целях снижения затрат и улучшения качества. Наибольшее понимание эта идея встречает у медиков Урала и Сибири (78%) и дальневосточного региона (88%). Представители администрации (84%), фармацевты(82%) и старшие медсестры (80%) также были настроены значительно более в пользу конкуренции, чем практикующие врачи и медсестры (63% и 58%, соответственно). Медики, которые уже сейчас часть своего дохода имеют за счет оказания платных услуг, более склонны к про-рыночной ориентации (85%), чем их коллеги, получающие только зарплату (65%).

Однако, целых три четверти (74%) российских медиков предпочитают вариант, при котором пациенту позволено заплатить врачам и медсестрам сверх обычного за некоторые виды лечения или же в некоторых медицинских учреждениях, причем почти половина из них (48%) отдает этому варианту явное предпочтение. И опять же, менее четверти 23% выступают против легализации этого процесса.

Здесь представлена преобладающая точка зрения по каждому региону и по каждой основной подгруппе. Надо заметить, что, фактически нет различия между позицией врачей и медсестер, чего не скажешь о представителях администрации и других группах медицинских работников.

УРОВЕНЬ ПРИНЯТИЯ РЕШЕНИЯ

	Уровень ЛПУ	Вышестоящий уровень
Найм на работу персонала	88%	11%
Установление зарплат и условий принятия на работу	32%	66%
Закупка оборудования	66%	27%
Выбор вида и марки оборудования	64%	27%

Принятие решения о том,

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каких пациентов обслуживать	66%	30%
Принятие решение о том, какие специалисты и процедуры предоставляются	56%	39%
Сдача в аренду помещений или продажа товаров третьей стороне	35%	53%
Увольнение персонала	89%	10%
Распределение средств, заработанных посредством обслуживания в частном порядке или же за пределами прикр. района	40%	34%
Покупка лекарств	75%	21%
Выбор главного врача	19%	72%
Определение режима лечения, продолжительности пребывания	59%	30%

Как видно из предшествующей таблицы, сохраняется ряд важных вопросов, решение по которым принимается не больницей или поликлиникой, а вышестоящими органами управления. Понятно, что вопросы найма и увольнения рабочей силы находятся, прежде всего, в компетенции учреждения, и 90% опрошенных отвечают утвердительно на вопрос, следует ли оставить эти функции в компетенции руководства ЛПУ.

В противоположность этому, существует ряд вопросов, которые решаются главным образом за пределами учреждения. Лишь 19% врачей, медсестер и администрации выражают мнение, что выбор главного врача является внутренним решением, и только 32% аналогичным образом думают об установлении размеров зарплат и условий приема на работу. Лишь 35% медиков, работающих главным образом в городах и небольших учреждениях, могут принимать решение по вопросу о сдаче помещений в аренду или же продаже товаров третьим лицам.

В общем и целом, городские медицинские учреждения пользуются большей свободой действий и свободой при принятия решений, чем медицинские учреждения в условиях, приближенных к сельской местности. Аналогично, очень крупные и очень маленькие учреждения имеют тенденцию к самостоятельности, тогда как для случая учреждений, по размеру попадающих в группу средних (50-200

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человек в штате), принятие решений за их пределами становится более характерным.

На вопрос, которые из этих решений Вы бы предпочли, чтобы они принимались в рамках самого учреждения, а не за его пределами, медики отвечали, принимая во внимание опять же узкие интересы своего учреждения. 45% указали, что прежде всего они бы хотели, чтобы решения о размере зарплаты и условиях приема на работу принимались самим учреждением; за такой порядок высказались наиболее отчетливо сельские медики (59%), в отличии от городских (40%), и медсестры (64%). 14% высказались за право выбора главного врача самим учреждением; главным образом, это были врачи (17%) и младший медицинский персонал (18%). Еще 7%, в основном, практикующие врачи и работники поликлиник, хотят иметь возможность закупать оборудование самостоятельно.

Представителям администрации были заданы дополнительно вопросы относительно нескольких других аспектах процесса управления, т.е. приходилось ли им лично принимать следующие решения.Результаты опроса представлены в ниже-следующей таблице:

	ДА	НЕТ
Распределять бюджет больницы/клиники	55%	45%
Брать кредиты (напр..на покупку оборудования /материалов)	39%	59%
Увеличивать площадь учреждения за счет пристроек	40%	57%
Ремонтировать здание	72%	28%
Изменять тип предоставляемых услуг	61%	39%
Менять систему оплаты труда	48%	52%

Единственное решение, которое большей частью оставляется в компетенции администрации больницы или поликлиники, - это ремонт здания, хотя в то же время им не позволяется самостоятельно решать вопрос о строительстве пристроек.

Наиболее интересные данные собраны по вопросу о возможностях изменять систему оплаты труда; так, почти половина администраторов (48%) сказала, что уже сегодня они обладают такими полномочиями. Это наиболее важный аспект руководства медицинским учреждением, который администраторы хотели бы иметь под своим контролем, если такового еще нет. Полномочия изменять систему оплаты труда имеются у 68% административных работников центральной/северной

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России и 57% в городах. Половина представителей администрации поликлиник (51%) могут изменять систему оплаты труда, и лишь 35% администраторов больниц могут принимать такие решения. Небольшие учреждения обладают такими возможностями в большей степени, чем крупные.

Кроме того, большинство тех же подгрупп администраторов имеют право на самостоятельное распределения своего бюджета. Надо заметить, что почти в каждом случае, когда представители администрации пользуются большей свободой при принятии решений в управлении, наблюдается большая поддержка реформам с их стороны и осознание, что причиной нынешних бед здравоохранения является старая советская система. И наоборот, те, кто лишены возможности принимать сами такие решения, склонны винить реформаторов в проблемах здравоохранения и склонны к неприятию реформ.

СУЩЕСТВУЮЩИЕ ФИНАНСОВЫЕ СИСТЕМЫ

Первым моментом, который следует подчеркнуть это то, насколько несведуща в этой области большая часть медиков. По многим вопросам, большинство медиков оказалось неспособным даже дать приблизительную оценку финансовой системы их учреждения.

Относительное большинство опрошенных медиков работают в учреждениях, которые напрямую финансируются государственными органами здравоохранения (39%), тогда как 14% финансируются министерством здравоохранения. Лишь 3% сказали, что они финансируются за счет страхования, а 5% - на самофинансировании.6% финансируются предприятиями, 3% указали, что их источник финансирования отличен от всех выше названных, и 11% опрошенных не смогло ответить на этот вопрос.

Несколько учреждений имеет более одного источника финансирования, так, 13% указало, что их финансирование складывается из поступлений от государства и страховых компаний, а 5% указало, что их финансирование имеет в качестве источников государственные ассигнования, страховые выплаты и оплата свмих пациентов. Такие учреждения более вероятно найти на юге России и в дальневосточном регионе страны.

Те, чье финансирование исходит исключительно от государственных органов здравоохранения, чаще являются сельскими медицинскими учреждениями (51%), в противовес городским (35%), и обычно это больница (50%), а не поликлиника (35%). Около 65% медиков центральной и северной России сообщили, что финансирование их учреждения осуществляется либо госорганами здравоохранения, либо министерством здравоохранения. Никто из медицинских работников этого региона не указал, что его финансирование происходит лишь за счет страховых выплат.

Чистое самофинансирование встречается только в городах (7%) и в поликлиниках (7%).Также в таких учреждениях обычно штат не превышает 50 человек(14%).

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Учреждения, операющиеся на сочетание государственного и страхового финансирования чаще встречаются на юге России (22%) и в дальневосточном регионе страны (21%). Не просматривается прямой связи между размером учреждения и наличием смешанного государственного и страхового финансирования. Поликлиники (13%) и больницы (14%) в равной степени представлены как имеющие данную систему финансирования.

Большие поликлиники явно преобладают среди тех учреждений, которые финансируются государством, страховыми компаниями и за счет предоставления платных услуг.

Среди медиков, указавших, что часть финансирования поступает от страховых компаний, большинство (55%) не имело понятия о размере доли страховых средств. 28% заметили, что менее 30% их дохода поступает из этого источника, в то времы как 17% говорят, что более 30% приходится на долю страховых средств.

Учреждения, которые операются главным образом на страховое финансирование встречаются чаще всего на Урале и в Сибири и в дальневосточном регионе страны. Учреждения, в которых большая часть финансирования происходит за счет страховых средств, чаще оказываются поликлиниками (19%), чем больницами (12%). Кроме того, как правило, это учреждения средние по размеру (38%).

Медики также очень плохо осведомлены о типе системы оплаты труда, используемой в их учреждении. Лишь менее половины работников поликлиник (50%) смогли сказать, каким образом производится оплата их труда; среди работников больниц только 40% смогли это объяснить.

Среди работников поликлиник 34% получают фиксированную зарплату, 4% оплачиваются сдельно в зависимости от количества процедур, 7% - от числа принятых больных, и 4% - сочетание двух последних систем.

Среди работников больниц 27% указывают, что размер оплаты их труда - вопрос, подлежащий обсуждению, 5% оплачиваются сдельно по количеству пациентов, 3% по количеству коек и лишь 1% - по количеству дней пребывания пациентов в больнице.

Поскольку большая часть медиков не знакома с нынешним порядком финансирования, неудивительно, что предсказать влияние, которое окажет введение системы страховой медицины на их учреждение, представляло сложность для них. 42% не знают точно, как это может повлиять на них; двое из десяти медиков указали, что это приведет к улучшению ситуации, а 28% считают, что это приведет к ухудшению. Еще 11% полагают, что влияние страховой медицины будет незначительным.

Просматривается явная географическая зависимость в ответах на этот вопрос. В то время как в одном регионе одна четверть(25%) сельских медиков расценивает введение страховой медицины положительно, в других регионах России эта цифра может снизиться на 7 пунктов (до 8%).

Фактически, медики Урала и Сибири настроены наиболее оптимистично, тогда как

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на юге России этот показатель снижается до 19% и до менее 13% на Дальнем Востоке и центральной и северной России.

Тогда как не существует расхождения во мнениях между поликлиниками и больницами по этому вопросу, ожидание положительного эффекта от внедрения страховой медицины сильно зависит от размера учреждения, причем крупные учреждения более оптимистично настроены по отношению к реформе (28%). 21% медиков, занятых в учреждениях среднего размера, думают, что страховая медицина окажет позитивное воздействие, в небольших медицинских учреждениях процент работников, утверждающих то же, - 16%.

Респонденты, получающие часть своего дохода за счет платных услуг, и медики с высокими доходами также настроены более позитивно в отношении значения страховой медицины. Респонденты, считающие, что старая советская система является причиной бедственного положения здравоохранения сегодня, тоже склонны к позитивной оценке по этому вопросу.

ВОЗМОЖНЫЕ СИСТЕМЫ ПРИ РЕФОРМИРОВАНИИ

Система страховой медицины

Респондентам также был задан вопрос о том, какие модели системы здравоохранения используются в других странах и о возможности перенесения их на российскую почву. Первая гипотетическая модель была описана следующим образом: "В некоторых странах, таких как Франция, Германия и Нидерланды правительство финансирует здравоохранения путем выделения средств страховым компаниям вместо финансирования напрямую медицинские учреждения, такие как больницы и поликлиники. Медицинские учреждения являются частными, и все вопросы решают сами". Целых 57% медиков указывают, что они бы поддержали установление в России подобной системы, и лишь 22% выступают против нее.

Между городскими и сельскими медиками существует разрыв в 5 пунктов по вопросу о поддержке системы такого типа: 61% сельских медиков отдают предпочтение такой системе и 56% городских. Поддержка реформам имеет тенденцию быть значительно более ощутимой на Дальнем Востоке (67%) и на Урале/в Сибири (64%) и более умеренной в центральной и северной России (58%). Южная Россия - единственный регион страны, где поддержка для этой системы ниже 50%-ной отметки (48%).

Работники поликлиник выглядят более открытыми для реформ (60%), чем их коллеги в больницах(53%) и аптеках(57%). И это особенно характерно для работников поликлиник, прикрепленных к предприятиям (69%).

Как и все население в целом, медики тем более активно поддерживают реформирование системы здравоохранения, чем они моложе, и наоборот, чем они старше, тем сильнее оппозиция. Целых 68% медиков в возрасте до 35 лет высказываются в поддержку введения страховой медицины, а также 61% медиков в возрастной группе 35-44 года. Поддержка уменьшается в возрастной группе 45-54

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года (48%) и среди тех, кому за 55 лет (35%).

Примечательно, что удовлетворенность существующей системой не оказывает влияния на позицию поддержки для системы нового типа, поскольку 58% недовольных системой и 57% довольных системой заявляют о своей поддержке введению системы нового типа. Однако, то как медики объясняют проблемы нынешней системы, значительно сказывается на отношении к реформам: целых 87% из тех, кто винят советскую систему, поддерживают реформы, и только 48% из тех, кто винят реформаторов.

Из тех, кто согласен с положением, что конкуренция улучшает качество медицинских услуг при снижении затрат, 63% поддерживают введение новой системы по типу системы в Германии и Франции. Среди тех, кто против идеи конкуренции, процент поддерживающих равен лишь 47%.

Однако, респонденты не уверенны в том, какое влияние подобная новая система окажет на их учреждения. 38% полагают, что при системе, когда "учреждение является частным, и все вопросы решает само, но не получает прямого финансирования от государства", их учреждение могло бы оказывать более качественную медицинскую помощь, чем в настоящее время. Тем не менее, одна четверть (25%) медиков думают, что это не приведет ни к каким изменениям в работе их учреждения, а 18% даже говорят, что качество медицинской помощи ухудшится.

Наиболее оптимистичный взгляд на систему, предполагающую непрямое государственоу финансирование и переход медицинских учреждений в частные руки, высказывается на Дальнем Востоке (63%) и на Урале/Сибири (42%), тогда как на юге России - 39%, а в центральной и северной России - 28%. Хотя сельские медики в основном положительно расценивают влияние новой системы на медицинскую помощь, оказываемую в их учреждении (42% сельские медики и 36% - городские), респонденты в крупных городах с населением, превышающим 500 тыс.чел., с большим энтузиазмом поддерживают такую реформу (45%), считая, что она позволит улучшить медицинское обслуживание там, где они работают.

Представители администрации скорее всего отзывались о таком шаге как о позитивном для их учреждения - 50%, врачи реже - 40% и фармацевты - 39%, что тоже свидетельствует о достаточной поддержке. Медсестры и младший медицинский персонал выглядят наиболее критически настроенными к такой перемене (29% и 24%, соответственно, - тех, кто верит, что новая система улучшит работу их учреждения).

Большинство медиков предсказывают рост затрат при системе, смоделированной по примеру французской или американской. 64% медиков, причем 75% медиков в сельских районах, предвидят увеличение затрат как результат внедрения новой системы, и лишь 4% считают, что затраты сократятся. 11% предсказывают, что цены останутся прежними, в то же время 22% не смогли сказать, какое же воздействие окажет новая система на затраты.

Трастовая система здравоохранения

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Затем респондентам была описана система, предполагающая медицинские трасты, следующим образом:"в некоторых странах, таких как Великобритания, Швеция, Дания и Финляндия правительство является собственником больниц и клиник, однако, они функционируют самостоятельно, и сами решают все вопросы. Государство платит медицинским учреждениям в зависимости от числа пролеченных больных или же в соответствии с договорами, заключаемыми каждый год." Поддержка для такой системы была впечатляющей - 78%,т.е. 4 из 10 медиков поддержали ее. Лишь 7% высказались против новой системы такого типа, и еще 15% не могли ответить.

Поддержка для такой системы здравоохранения в России наиболее сильна в центральном и северном регионах и на на Дальнем Востоке (84% И 83%, соответственно). Поддержка снижается до 77% на юге России и 68% в уральско-сибирском регионе. В целом, сельские медики продемонстрировали на 6 пунктов большую поддержку для системы, смоделированной по образцу британской, чем их городские коллеги - 82% и 76%.

Поддержка характерна как для работников поликлиник, так и для больниц, и особенно - для медсанчастей (83%) и поликлиник с более, чем 15 врачами (86%). Примечательно, что на отношение к системе этого типа не влияет возраст и отношение к конкурентной модели системы здравоохранения.

Респонденты выражают большую уверенность в том, что этот тип системы окажет благотворное влияние на их собственное медицинское учреждение: 61% указывают, что медицинское обслуживание улучшится при трастовой системе здравоохранения, и лишь 5% считают, что положение ухудшится. Единственно, кто дал ощутимую негативную оценку, - это медики в наиболее крупных городах (12% сказало, что будет хуже) и работники больниц (10%).

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RUSSIA HEALTH CARE - CONSUMER

FINAL

Hello, I'm _____ of _____, a national research firm. We're talking to people in the republic of Russia today about public and economic issues facing us all.

Thinking for a moment about the state of Russia --

1. Generally speaking, do you feel things here in Russia are going in the right direction, or are they off on the wrong track?

IF CHOICE MADE, ASK: And do you feel strongly about that?	Right direction/strongly . . . 5%
	Right direction 17%
	UNSURE (DNR) 17%
	Wrong track 41%
	Wrong track/strongly 20%

Now I would like to read you a list of issues that some people from this part of the country have said are important problems facing Russia today. Please listen as I read the list and tell me which one issue you think is most important. **(READ AND ROTATE ISSUES)**

	Q2 MOST IMPORTANT
1) National political leadership	30%
2) Interethnic conflicts	6%
3) Shortages of goods/food	1%
4) Health care	2%
5) Crime	14%
6) High prices	17%
7) Unemployment	11%
8) COMBINATION/EQUALLY (DNR)	15%
9) UNSURE (DNR)	3%

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*INDICATES LESS THAN 1%

Still thinking about things here in Russia --

3. Being as specific as you can, what is the number one problem facing you personally -- that is, what is the problem that you (and your family) are most concerned about? **(PROBE: PLEASE TELL ME MORE ABOUT THAT)**

Health problems	10%
High prices, inflation, finance problem	40%
Unemployment, how to find job	10%
Crime, afraid to go along the streets	4%
Moral, loneliness	1%
Housing problem, how to renovate housing	7%
Uncertainty, afraid of future	3%
Interethical problem break up the Soviet Union	1%
Social problems	3%
Family problems	1%
Children's problems	3%
Problems in college, education	*
Personal problems	2%
Lack of food	1%
Working conditions	*
Problem on the farm	1%
State problems: political/social	5%
Environment pollution	*
Delay tp pay salary, pensions	2%
Problems in the household (no hot water, bad road near house)	1%
Many problems	*
No problems	3%
Do not know	2%

Now, I am going to read you several organizations in Russia. Please tell me, for each one, how you would rate the job that organization is doing -- would you say that it is doing an excellent, good, satisfactory, or unsatisfactory job?

(ROTATE 4-6)	Excellent	Good	Satis	Un-Satis	UNSURE/ NO OPIN (DNR)
4. The Ministry of Health	1%	11%	42%	31%	15%
5. The Duma	*	2%	19%	44%	34%
6. GKI	*	2%	18%	36%	43%

Now, thinking specifically about your local polyclinic for a moment --

7. Do you approve or disapprove of the way your local polyclinic is taking care of your community's health care needs?

IF CHOICE MADE, ASK: And do you strongly or somewhat (approve/disapprove)?

Approve/strongly	20%
Approve/somewhat	40%
UNSURE (DNR)	9%
Disapprove/somewhat	18%
Disapprove/strongly	12%

Now, thinking specifically about the Oblast Health Committee for a moment --

8. Do you approve or disapprove of the way the Oblast Health Committee is taking care of your community's health care needs?

IF CHOICE MADE, ASK: And do you strongly or somewhat (approve/disapprove)?

Approve/strongly	9%
Approve/somewhat	27%
UNSURE (DNR)	40%
Disapprove/somewhat	13%
Disapprove/strongly	11%

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Now, thinking about your own health --

9. Would you say that you personally are in excellent, good, fair or poor health?

Excellent	3%
Good	25%
Fair	48%
Poor	23%
UNSURE (DNR)	1%

And --

10. Have you or a member of your immediate family had to use unpaid professional medical services (your local medical center) in the last two years?

Yes (TO 11-14)	82%
No (TO 15)	19%
UNSURE (TO 15)	*

IF "YES" IN QUESTION 10, THEN ASK:

11. What type of medical facility provided that care?

Hospital	20%
Polyclinic	71%
Doctor visit	8%
Midwife/non-professional	1%
OTHER _____	*
UNSURE (DNR)	*

(CONTINUE TO 12)

---

12. And, what type of medical care or service was provided at that time?

Surgery	8%
Broken bone/leg/rib/hip	2%
Emergency service/accident	1%
General examination	6%
Pediatric care	6%
Child birth/prenatal care	2%
Immunization/vaccination	1%
Cancer treatment	1%
Pneumonia/bronchitis/flu	7%
Heart attack/cardiac care	6%
Blood test/care/high blood pressure	8%
Stroke	1%
Diabetes	2%
Neurological problem	6%
Stomach/ulcer/gall bladder	6%
Arthritis	2%
Infection	3%
X-ray	1%
Geriatric problem	*
Other	7%
DON'T REMEMBER/REFUSED	*

(CONTINUE TO QUESTION 13)

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13. Did you have to offer gifts or informally pay doctors or nurses yourself for these services?

Yes	14%
No	86%
UNSURE (DNR)	*

(CONTINUE TO QUESTION 14)

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14. And, how would you rate the medical care that you received? Would you say it was... **(READ CHOICES)**

Excellent	7%
Good	38%
Fair	46%
Poor	8%
UNSURE (DNR)	1%

**** ASK OF EVERYONE ****

15. Now, have you had to use <u>paid</u> professional medical services in the last two years?

Yes **(TO 16-18)**	22%
No **(TO 19)**	78%
UNSURE **(TO 19)**	*

<u>IF "YES" IN QUESTION 15, THEN ASK</u>:

16. What type of medical facility provided that care?

Hospital	10%
Polyclinic	70%
Doctor visit	6%
Midwife/non-professional	8%
OTHER _____	7%
UNSURE (DNR)	*

(CONTINUE TO 17)

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17. And, what type of medical care or service was provided at that time?

Surgery	3%
Broken bone/leg/rib/hip	2%
Emergency service/accident	*
General examination	8%
Pediatric care	2%
Child birth/prenatal care	2%
Immunization/vaccination	1%
Cancer treatment	1%
Pneumonia/bronchitis/flu	2%
Heart attack/cardiac care	5%
Blood test/care/high blood/ pressure	1%
Stroke	*
Diabetes	*
Neurological problem	5%
Stomach/ulcer/gall bladder	4%
Arthritis	1%
Infection	1%
X-ray	1%
Geriatric problem	1%
Other	15%
DON'T REMEMBER/REFUSED	*

(CONTINUE TO QUESTION 18)

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18. And, how would you rate the medical care that you received? Would you say it was... **(READ CHOICES)**

Excellent	15%
Good	42%
Fair	27%
Poor	12%
UNSURE (DNR)	4%

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**** ASK OF EVERYONE ****

19. How satisfied are you with your current health care? -- Would you say you are extremely satisfied, very satisfied, somewhat satisfied, or not satisfied at all?

Extremely satisfied (TO 20)	9%
Very satisfied (TO 20)	20%
Somewhat satisfied (TO 19-1)	39%
Not satisfied (TO 19-1)	16%
NOT HAD TO USE HEALTH CARE (DNR) (TO 20)	12%
UNSURE (DNR) (TO 20)	5%

IF "SOMEWHAT SATISFIED" OR "NOT SATISFIED" IN QUESTIONS 19, THEN ASK:

19-1. And, being as specific as you can, what are two or three of the most important reason why you are not satisfied with your health care? **(PROBE: PLEASE TELL ME MORE ABOUT THAT)**

Not effect from treatment	1%
Doctors are incompetent, bad-trained	6%
Doctors are irresponsible, rude, very formal in treatment	9%
Bad technical equipment	8%
High fees for treatment, medicines	4%
Long lines to doctors, need to wait long time, ambulance car is always late	5%
Difficult to find medicines, not available	11%
Lack of specialists, need to go very far - to another city - to find doctor	2%
Refuse to provide medical services needed	1%
Can not give correct diagnosis	2%
Low quality of services	2%
Low material incentives for doctors to treat people	*
Bad preventative help and information	*
No 'individual" treatment	2%
Medical facilities are dirty, bad conditions	1%
Inconvenient hours of work of medical facilities - only during the day	1%
Unsure	6%

**** ASK OF EVERYONE ****

20. And, do you think that health care here in Russia will get better, get worse or stay about the same in the next ten years?

Get better	32%
Get worse	21%
About the same	21%
UNSURE (DNR)	26%

And --

21. How confident are you that when you get sick, the doctor that sees you is well trained and able to meet your needs? Are you -- extremely confident, very confident, somewhat confident, or not confident at all -- than your doctor can meet your needs?

Extremely confident	9%
Very confident	9%
Somewhat confident	37%
Not confident at all	38%
UNSURE (DNR)	6%

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Now, thinking about the availability of medicines in Russia today --

22. In your experience, has the availability of medicine or legal drugs in the past few months -- gotten better, gotten worse, stayed about the same, or is it not available at all?

Gotten better	30%
Gotten worse	41%
About the same	17%
Not available at all	3%
UNSURE (DNR)	8%

And --

23. Do you think the quality of drugs and medicines in Russia today is -- better, worse or about the same as a few years ago?

IF CHOICE MADE, ASK: And do you feel strongly about that?

Better/strongly	5%
Better	14%
UNSURE (DNR)	30%
About the same	42%
Worse	8%
Worse/strongly	2%

And --

24. If your local pharmacy were to stock goods other than drugs and medicine, such as cosmetics and convenience items, would you consider buying these items from a pharmacy or would you continue to buy them where you do now?

Pharmacy	36%
Where buy now	16%
BOTH (DNR)	27%
NEITHER (DNR)	16%
UNSURE (DNR)	5%

Now, thinking about the future of health care in Russia --

25-1. How much do you personally worry that you might be required to pay for you and your family's basic medical care? Does it personally worry you -- a great deal, somewhat, or not very much?

Great deal	70%
Somewhat	19%
Not very much	7%
NOT AT ALL (DNR)	4%
UNSURE (DNR)	1%

And, thinking about catastrophic illnesses, such as debilitating accidents, or diseases like cancer or heart problems --

25-2. How much do you personally worry about not being able to pay for medical care if you or a member of your family suffered from a catastrophic illness in the future? Does it worry you -- a great deal, somewhat, or not very much?

Great deal	81%
Somewhat	12%
Not very much	4%
NOT AT ALL (DNR)	2%
UNSURE (DNR)	1%

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26. Have you seen, read or heard anything about the new government insurance law recently?

Yes (27 & 28)	57%
UNSURE (DNR) (TO 29) . . .	*
No (TO 29)	43%

IF "YES" IN QUESTION 26, ASK:

27. Are you aware of the voluntary insurance provisions of the new law that allows for greater medical coverage through voluntary contributions in addition to the mandatory basic coverage?

Yes/aware	61%
No/not aware	39%
UNSURE (DNR)	*

(CONTINUE TO QUESTION 28)

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28. Thinking about what you have seen, read or heard about this, do you think the new government health care insurance system will improve the health care you receive or will it make it worse?

IF CHOICE MADE, ASK:
And do you feel strongly about that?

Improve/strongly	6%
Improve	32%
UNSURE (DNR)	26%
NO DIFFERENCE (DNR) . .	26%
Worse	6%
Worse/strongly	4%

** ASK OF EVERYONE **

29. Have you seen, read or heard any of the government's campaigns to educate you and your family about public health issues that promote a healthier lifestyle, such as the hazards of cigarette smoking, excessive alcohol drinking, or anything else?

Yes (TO 30)	66%
No (TO 31)	34%
UNSURE (DNR) (TO 31) . . .	*

IF "YES" IN QUESTION 29, THEN ASK:

30. Have these education efforts by the government caused you to change any habits or do anything differently than before?

Yes/changed	24%
No/have not changed . .	76%
UNSURE (DNR)	*

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**** ASK OF EVERYONE ****
Now I'd like to read you two viewpoints about keeping healthy. Please tell me which one comes closest to what you practice in your daily life. **(READ & ROTATE ALTERNATIVES)**

31. Some people say/ Other people say — that it is better to prevent illness by doing things such as seeing a doctor once a year for a physical examination, exercising and eating right.

    Other people say/ Some people say — that you only really need to see a doctor when you are sick. Besides, exercise and changing your habits is more bother than it is worth and will not help you that much anyway.

"Which viewpoint comes closest to your own?"	
Prevent	71%
More bother than it will help	11%
BOTH EQUALLY (DNR)	13%
UNSURE (DNR)	5%

Still thinking about health care here in Russia --

32. Have you not gone to seek medical care for you or a member of your family recently because of concerns about the quality of the care, whereas in the past you probably would have sought care?

Yes	16%
No	81%
UNSURE (DNR)	4%

And, thinking about any time in the last two years that you or a member of your family has had to wait an "excessive amount" of time for a medical procedure or to see a doctor --

33. Would you say the longest you have had to wait is -- one day, two-six days, one week, two weeks, one month, or more than one month?

One day	14%
2-5 days	9%
One week	6%
Two weeks	3%
One month	3%
More than one month	2%
NEVER HAD TO WAIT LONG(DNR)	49%
NOT USED MEDICAL CARE IN LAST TWO YEARS (DNR)	11%
UNSURE (DNR)	4%

As you may be aware, Russia's health care system is currently undergoing major changes and experiencing a number of difficulties. If you could tell the leaders in Moscow, one health care issue that they should work on first, which of the following would it be -- **(READ LIST AND ROTATE)** --

	Q34 TOP PRIORITY
1) Vaccinating young children	3%
2) Improving the water purification plants	2%
3) Reducing pollution in the environment	16%
4) Training doctors and nurses in the most modern procedures and health care techniques	10%
5) Keeping hospitals and polyclinics supplied with necessary equipment and drugs	39%
6) Keeping pharmaceutical factories operating	5%
7) Educating the public about the hazards of smoking and drinking	1%
8) COMBINATION/EQUALLY (DNR)	22%
9) UNSURE (DNR)	3%

Now I would like to read you a list of issues that some people from this part of Russia have said worry them about the state of health care in Russia today. Please listen as I read the list and tell me which one issue worries you the most. **(READ AND ROTATE ISSUES)**

	Q35 BIGGEST WORRY
1) Doctors are not properly trained and will make a mistake in treating me or my family member	18%
2) Government will run out of money to fund the health care system and we will have to pay more than I can afford for treatment	30%
3) I will need surgery or emergency care but the hospital will not have anesthesia or the proper supplies	16%
4) My children will need medicine or a vaccination, but there will be none available	8%
5) I will find out that I have a disease or ailment, that could have been prevented if I had been properly informed	5%
6) COMBINATION/EQUALLY (DNR)	19%
7) UNSURE (DNR)	4%

Now I would like to read you a series of possible objectives or aims in reforming our health care system. As I read them please tell me which one you would most prefer to be one of the aims in reforming our health care system --

36. Would you prefer . . . **(READ CHOICES AND ROTATE)**

- Keeping medical care free to all Russians

-- OR --

- Making sure the quality of the health care you and your family receives is the best it can be even if it means paying something

Free care	55%
Quality care	40%
UNSURE (DNR)	5%

Still thinking about your preferred objectives in reforming our health care system --

37. Would you prefer . . . **(READ CHOICES AND ROTATE)**

- Restricting the types of medical procedures you can receive free of charge if the quality of basic care improves

-- OR __

- Making sure all Russians have access to all types of medical procedures if the quality of care were to remain as it is now

Restrict/better quality	60%
No restrictions	36%
UNSURE (DNR)	5%

And --

38. Now, I would like to read you a statement that some people in this area agree with and others disagree with. Please tell me whether you personally agree or disagree.

"The health care system we have in Russia is an inherently good system and the current problems are only temporary."

IF CHOICE MADE, ASK: And do you strongly (agree/disagree) or somewhat (agree/disagree) of that?	Agree/strongly 16%
	Agree/somewhat 38%
	UNSURE (DNR) 10%
	Disagree/somewhat . . . 20%
	Disagree/strongly . . . 16%

Now I'd like to read you two viewpoints and please tell me which one comes closest to your own. **(READ & ROTATE ALTERNATIVES)**

39. Some people say/ Other people say — that people should never have to pay for medical care as they cannot afford basic care and should only have to pay for "extra comforts," such as private rooms or very expensive treatment methods.

Other people say/ Some people say — that patients paying for medical services is the only way to create competition among doctors and force them to provide better quality care while still keeping fees at reasonable rates.

"Which viewpoint comes closest to your own?"	Should not pay for services 53%
	Should pay for services 21%
	BOTH EQUALLY (DNR) 22%
	UNSURE (DNR) 4%

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And --

40. If cost were not a factor and you could go anywhere to receive medical care, which of the following would you probably go to for non-emergency care? Would you go to -- **(ROTATE)** -- • your local polyclinic, • a local private doctor, • a large clinic in a nearby (or another) city, • a private doctor in a nearby (or another) city?

Local polyclinic	46%
Local private doctor . .	22%
Polyclinic in another city	10%
Private doctor in another city	8%
Good specialist	3%
Foreign specialist . . .	1%
High prestige Poly. . . .	*
Private Polyclinic	*
Family doctor	1%
Research Center	1%
Don't go anywhere . . .	1%
OTHER **(DNR)**	1%
UNSURE **(DNR)**	8%

Now I would like to read you several medical procedures or treatments that might not be considered "basic care" and that the government might not be able to pay for someday. Please tell me, for each one, whether you would be willing to pay extra to have this care. Here is the first one...

	(ROTATE LIST)	WILLING	NOT WILLING	UNSURE (DNR)
41.	Psychiatric care/therapy	31%	58%	11%
42.	Contraceptives/family planning	35%	48%	18%
43.	Alcohol abuse treatment	37%	49%	14%
44.	Preventative examinations	36%	57%	7%
45.	Prescriptions/medicine for children	45%	49%	6%
46.	Eyeglasses/optometric exam	45%	46%	9%

(END ROTATION)

There has been some discussion about creating some hospitals and polyclinics that are not run by the government, but are run by "Health trusts." This means that while the government still maintains certain standards for things such as safety, the administration of the hospital is in the hands of a church, charity, union or some other private group that does not make a profit off of the enterprise.

47. Would you be willing to go to a hospital or polyclinic run by a health trust rather than a government-run one?

IF CHOICE MADE, ASK:
And do you feel strongly about that?

Yes/strongly willing . .	17%
Yes/willing	38%
UNSURE **(DNR)**	13%
No/not willing	21%
No/strongly not willing	12%

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Now, what if the hospital or polyclinic was owned by a private group, such as a groups of doctors that also work there, but the group might make a profit if they do well enough --

48. Would you be willing to go to a private hospital or polyclinic rather than a government-run one?

IF CHOICE MADE, ASK: And do you feel strongly about that?	
Yes/strng willing(TO 50)	10%
Yes/willing (TO 50) . .	45%
UNSURE (DNR) (TO 50) . .	10%
No/not willing (TO 49) .	19%
No/strongly not (TO 49)	17%

IF ANY "NOT WILLING" IN QUESTION 48, THEN ASK:

49. What is the single most important reason why you would not go to a privately-run polyclinic or hospital?
(PROBE: PLEASE TELL ME MORE ABOUT THAT)

Do not trust quality of service (afraid to be infected	8%
Do not have money to pay for services, they will be to expensive for me	36%
Do not trust specialists working in private hospitals	31%
Private clinics are out of any control . . .	13%
Do not think the treatment in private clinic will be better than in state-run one	1%
I didn't see any of such clinics, no experience to treat in private organizations	2%
Other	4%
Do not know	*

**** ASK OF EVERYONE ****

Now I'd like to read you two viewpoints and please tell me which one comes closest to your own. **(READ & ROTATE ALTERNATIVES)**

50. Some people say/ Other people say that allowing individuals and businesses to run Russia's hospitals and pharmaceutical companies will make hospitals be more responsive to their patients' needs and eliminate the widespread inefficiencies of the state-run system through healthy competition.

Other people say/ Some people say that allowing individuals and businesses to run the health care system will only make health care unaffordable for most Russians while letting these people get rich off our misery.

"Which viewpoint comes closest to your own?"	
Will be better	23%
Will be worse	52%
BOTH EQUALLY (DNR)	19%
UNSURE (DNR)	7%

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Now, I am going to read to you a series of statements that some people in Russia have made about health care in the country. Please listen as I read each one and tell me if you agree or disagree with the statement. **(READ AND ROTATE)** **IF CHOICE MADE, ASK:** Is that strongly (agree/disagree) or somewhat (agree/disagree)?

	AGREE Strng	AGREE Smwht	UNSUR (DNR)	NO DIFF. (DNR)	DISAGREE Smwht	DISAGREE Strng
51. Western companies who are coming to Russia to sell drugs and medical equipment are only exploiting our people and should be barred from this market. **(PROMPT: DO YOU AGREE OR DISAGREE WITH THIS STATEMENT?)**	16%	26%	10%	3%	21%	24%
52. The health care system in Russia, must be universal even if it means lower standards of quality overall.	28%	30%	8%	1%	19%	14%
53. Doctors are so poorly trained, that I could probably take better care of myself than they would.	5%	18%	6%	1%	27%	42%
54. The outdated equipment in hospitals must be replaced before doctors can adequately care for their patients.	74%	21%	3%	1%	1%	1%
55. Privatization is always a bad thing.	27%	18%	29%	4%	14%	8%
56. Russian doctors are actually better than Western doctors, because they have been able to care for people even without the modern drugs and expensive equipment.	25%	34%	20%	2%	12%	8%

(END ROTATION)

Now, just a few final questions for statistical purposes only --

57. You are now:

Employed/working **(TO 58-59)**	56%
Temporarily jobless **(TO 60)**	5%
Retired or disabled **(TO 60)**	30%
Running household/bringing up children **(TO 60)**	2%
Hunting for a job **(TO 60)**	4%
Studying somewhere **(TO 60)**	3%
Active military **(TO 60)**	1%
Other **(TO 60)**	*
UNSURE **(DNR) (TO 60)**	*

IF "EMPLOYED" THEN ASK:

58. Are you a... **(READ LIST)**

Factory/Industrial worker	46%
Engineer	14%
Intellectual not engaged in manufacturing	8%
White collar/office worker	26%
Doctor/nurse/health care field	5%
Agriculture	1%
Entrepreneur	1%
Other	1%
NA	*

(CONTINUE TO 59)

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IF "EMPLOYED" THEN ASK:

Thinking about your workplace --

59. Are you employed by a private sector company, a state-run/ public sector company, or is it in a state of transition from public to private at this time?

Private	14%
Public	73%
Transition	10%
NEITHER(DNR)	*
UNSURE (DNR)	4%

(** ASK OF EVERYONE **)

60. Gender (BY OBSERVATION)

Male	38%
Female	63%

---

61. How old are you?

18-24	10%
25-29	9%
30-34	10%
35-39	12%
40-44	10%
45-54	15%
55-64	17%
65 and over	18%

---

62. What is your education? (DO NOT READ, JUST RECORD)

Seven grades or less	17%
High school incomplete	9%
High school graduate	25%
Some technical school	27%
Less than 3 years of college	3%
College graduate	18%

---

63. Taking into account all types of income of all your household members - salary, wages, scholarship, pensions, on the dole for child caring - what was the monthly average income per member over the past two or three months?

80K or less	17%
80K to 150K	22%
150K to 250K	21%
250K to 400K	17%
400K to more	10%
UNSURE/NO OPINION (DNR)	14%

---

64. Do you have children under the age of 18 living at home?

Yes (TO 65)	46%
No (TO 66)	54%
UNSURE/REFUSED(DNR)(TO 66)	*

IF "YES" IN QUESTION 64, THEN ASK:

65. Have your children received all the necessary vaccinations or immunizations?

Yes	80%
Almost/some	16%
No/not any	4%
UNSURE (DNR)	*

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RUSSIA HEALTH CARE - PROVIDER

FINAL

Hello, I'm _____ of _____, a national research firm. We're talking to people in the republic of Russia today about public and economic issues facing us all.

1. How satisfied are you with the current state of health care in Russia today -- Would you say that you are extremely satisfied, very satisfied, somewhat satisfied, or not satisfied at all?

Extremely satisfied (TO 4)	3%
Very satisfied (TO 4)	42%
Somewhat satisfied (TO 2-3)	30%
Not satisfied (TO 2-3)	26%
UNSURE (DNR) (TO 4)	*

IF "SOMEWHAT SATISFIED" OR "NOT SATISFIED" IN QUESTION 1, THEN ASK:

2. Who do you blame for the problems in the health care system today? **(DO NOT READ CHOICES)**

Old Soviet system/ communists	15%
Reformers in the government today	41%
The West/western companies	1%
Medical schools	1%
Hospital administrators	1%
Doctors	1%
Pharmaceutical industry	1%
Health Ministry	22%
Combination	15%
OTHER _____	2%
UNSURE	2%

---

*INDICATES LESS THAN 1%

IF "SOMEWHAT SATISFIED" OR "NOT SATISFIED" IN QUESTION 1, THEN ASK:

3. And, being as specific as you can, what is the most important reason that you are not completely satisfied with the state of health care in Russia and exactly how would you correct or improve this? **(PROBE: PLEASE TELL ME MORE ABOUT THAT)**

MAIN REASON YOU ARE NOT SATISFIED W/H.C.	
Low social status of profession	1%
Lack of medicines	6%
Lack of finance	39%
Some people cannot afford to pay	1%
Lack of equipment	2%
Too high working load	1%
Distraction in the country	5%
No self-supporting	1%
Wrong management	7%
Lack of qualifications	3%
Lack of quality norms	1%
Low salary	3%
Bad working conditions	1%
Orientation to individuals	1%
Low quality of services	1%
Not every service is available	1%
Don't know/no response	28%

HOW WOULD YOU IMPROVE THIS/1ST MENTION	
New insurance program	3%
Increase in state funding	29%
Provide equipment	2%
Provide medicine	1%
Change system as a whole	5%
People should pay	6%
Improve management	3%
Pay for quality	3%
Improve training	1%
Develop pharmaceutical industry	1%
Encourage private activity	1%
More nurses	1%
Increase responsibility	1%
Don't know/no response	45%

HOW WOULD YOU IMPROVE THIS/2ND MENTION	
Increase in state funding	2%
Increase salaries	2%
People should pay	3%
Improve management	2%
Improve training	2%
Educational campaign	2%
Don't know/no response	88%

** ASK OF EVERYONE **

Still thinking about the health care system in Russia today --

4. Compared to ten years ago, do you feel more secure, less secure or about the same about the health care system today?

More secure	7%
Less secure	78%
About the same	13%
UNSURE (DNR)	3%

Now, thinking about the current health care system of hospitals and polyclinics in your area --

5. Overall, would you say the staffs of these institutions are -- • very well-trained in the latest medical technologies, • well-trained but many could use some additional training in certain areas, • generally competent but most could use major training, • generally incompetent?

Very well-trained . . .	4%
Well-trained	21%
Competent	60%
Incompetent	12%
UNSURE (DNR)	4%

Now, thinking about the current system of apetkas in your area --

6. Overall, would you say the staffs of these institutions are -- • very well-trained in the latest medical technologies, • well-trained but many could use some additional training in certain areas, • generally competent but most could use major training, • generally incompetent?

Very well-trained . . .	2%
Well-trained	25%
Competent	50%
Incompetent	8%
UNSURE (DNR)	16%

Now, thinking about the availability of medicines in Russia today --

7. In your experience, has the availability of medicine in the past six to twelve months -- gotten better, gotten worse or stayed about the same?

Gotten better	36%
Gotten worse	52%
About the same	9%
UNSURE (DNR)	3%

---

8. Have you seen, read or heard anything about the government insurance law that came into effect last year?

Yes (9 & 10)	88%
UNSURE (DNR) (TO 11) . . .	*
No (TO 11)	12%

IF "YES" IN QUESTION 8, ASK:

9. Thinking about what you have seen, read or heard about this, do you think the government health care insurance system will improve the health care system or will it make it worse?

IF CHOICE MADE, ASK:
And do you feel strongly about that?

Improve/strongly	5%
Improve	24%
UNSURE (DNR)	15%
NO DIFFERENCE (DNR) . .	17%
Worse	23%
Worse/strongly	15%

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IF "YES" IN QUESTION 8, ASK:

10. And, how much of an impact do you think these new insurance laws will have on your job or others in your profession? Do you think it will have a major impact, a minor impact, or no impact at all?

Major	22%
Minor	31%
No impact at all	31%
UNSURE (DNR)	17%

Still thinking about the government's role in taking care of health needs --

11. What percentage of your income is derived from services that are in addition to your base salary from the government (privately paid for)?

0	76%
1	2%
5	2%
10	3%
15	1%
20	1%
25	*
30	*
35	1%
40	1%
45	*
50	*
60	*
75	*
100	*
Refused	7%
Unsure	5%

Now I would like to read you several medical procedures or treatments that might not be considered "basic care" and that the government might not be able to pay for someday. Please tell me, for each one, whether you think the government should have to cover this treatment in a basic care insurance package or whether patients should be willing to pay extra to give this care. Here is the first one...

	(ROTATE LIST)	GOVERNMENT	PATIENT	UNSURE (DNR)
12.	Psychiatric care/therapy	97%	2%	1%
13.	Abortions	25%	72%	3%
14.	Contraceptives/family planning	32%	66%	2%
15.	Alcohol abuse treatment	34%	60%	6%
16.	Preventative examinations	71%	26%	3%
17.	Prescriptions/medicine for children	98%	1%	1%
18.	Eyeglasses/optometric exam	38%	61%	2%

(END ROTATION)

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Now, thinking about government public education campaigns --

19. Do you participate in education efforts and public health campaigns?

Yes (TO 20)	54%
No (TO 21)	46%
UNSURE (DNR) (TO 21) . . .	*

IF "YES" IN QUESTION 19, THEN ASK:

What campaigns have you been involved in --

		MENTIONED	NOT MENTIONED
20-1)	Childrens' health issues	39%	61%
20-2)	Women's health issues	44%	56%
20-3)	Elderly care	40%	60%
20-4)	Catastrophic care	40%	60%
20-5)	Prevention issues, such as the hazards of cigarette smoking or drinking	87%	13%

** ASK OF EVERYONE **

Now, thinking about the current health care system --

21. Do you think that the current health care system adequately meets the needs of the Russian people?

Yes (TO 22)	19%
No (TO 23)	78%
UNSURE (DNR) (TO 23) . .	4%

IF "NO" OR "UNSURE" IN QUESTION 21, ASK:

22. Being a specific as you can, what incentives should be available to health providers and the bureaucratic system to allow them to better respond to the needs of the Russian people? **(PROBE: PLEASE TELL ME MORE ABOUT THAT)**

WHAT INCENTIVES SHOULD BE AVAILABLE/1ST	
Working conditions	2%
Modern Equipment	8%
Pay for person work	2%
More attention to rural	0%
Provide medicines and drugs	5%
Increase salaries	49%
Pay for qualifications	2%
Social security for doctors	2%
Pay for quality	3%
Prestige of profession	1%
Diagnosis	1%
Increase state budget	13%
Encourage private activity	1%
Change norms & standards	0%
Self-administration of facilities	3%
Improve training	2%
More information for people	1%
New norms of quality and quantity	0%
Information about medicine	0%
Change attitudes toward patients	1%
Unsure	3%

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WHAT INCENTIVES SHOULD BE AVAILABLE/2ND	
Working conditions	1%
Modern Equipment	14%
Pay for person work	1%
Provide medicines and drugs	10%
Increase salaries	9%
Pay for qualifications	2%
Social security for doctors	2%
Pay for quality	3%
Prestige of profession	4%
Diagnosis	1%
Increase state budget	2%
Benefits for doctors	6%
Increase quality of services	0%
Self-administration of facilities	2%
Improve training	4%
Introduce insurance	1%
More information for people	0%
Pay to doctors/not facilities	1%
New norms of quality and quantity	2%
Information about medicine	0%
Tax reduction	1%
State pay to poor people	0%
Develop medical facilities	0%
Unsure	32%

WHAT INCENTIVES SHOULD BE AVAILABLE/3RD	
Working conditions	3%
Modern Equipment	11%
Pay for person work	1%
Provide medicines and drugs	5%
Increase salaries	7%
Pay for qualifications	1%
Pay for quality	1%
Prestige of profession	2%
Decrease cost of medicine	1%
Increase state budget	3%
Encourage private activity	1%
Benefits for doctors	1%
Change norms & standards	1%
Self-administration of facilities	1%
Improve training	5%
Introduce insurance	1%
New norms of quality and quantity	1%
Organizations of work	1%
Privatization	1%
Free choice of doctors	1%
Unsure	50%

**** ASK OF EVERYONE ****

23. Do you think that having competition among health care providers, such as hospitals, polyclinics, pharmacies, and pharmaceutical manufacturers, would result in better care at lower costs?

IF CHOICE MADE, ASK: And do you feel strongly about that?	
Yes/strongly	34%
Yes	35%
UNSURE (DNR)	8%
No	12%
No/strongly	12%

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And --

24. Would you favor or oppose formally allowing patients to pay doctors and nurses extra payments for certain treatments or in certain facilities?

IF CHOICE MADE, ASK: And do you feel strongly about that?	
Yes/strongly	48%
Yes	26%
UNSURE (DNR)	3%
No	6%
No/strongly	17%

**** ASK OF DOCTORS/NURSES/HOSPITAL OR POLYCLINIC ADMINISTRATORS ****

Now, I am going to read you a list of decisions that in some places are made by the government and in some places are made by the medical facility (hospital or polyclinic). For each one, please tell if your facility controls that aspect of the health care process or does not. Here is the first one...

	(ROTATE LIST)	DOES	DOES NOT	UNSURE (DNR)
25.	Hiring of personnel	88%	11%	1%
26.	Setting salaries and conditions of employment	32%	66%	2%
27.	Purchasing equipment	66%	27%	7%
28.	Choosing the brand of equipment	64%	27%	10%
29.	Deciding which patients to accept	66%	30%	5%
30.	Deciding which procedures and specialties to offer	56%	39%	5%
31.	Renting space or selling goods to third parties	35%	53%	12%
32.	Firing personnel	89%	10%	1%
33.	Allocation of funds earned through private patients or patients outside of the local area	40%	34%	26%
34.	Buying medicines	75%	21%	4%
35.	Choosing the chief doctor	19%	72%	9%
36.	Deciding treatment regime and length of stay	59%	30%	11%

(END ROTATION)

Now, thinking about the aspects of health care that I listed that your facility does not control -- If you could gain control of one of these, which would be your first choice? IF CHOICE MADE, ASK: And what would be your second choice? **(DO NOT READ LIST)**

Hire personnel	3%
Set salaries/employment	45%
Purchase equipment . . .	7%
Choose brand of equipment	1%
Decide patients to accept	4%
Decide procedures to offer	2%
Rent space/sell assets .	2%
Fire personnel	*
Allocation of funds from private patients . . .	2%
Buy medicines	2%
Choosing chief doctor .	14%
Decide treatment regimes/ length of stay	2%
OTHER **(DNR)**	*
UNSURE **(DNR)**	18%

**** ASK OF HOSPITAL ADMINISTRATORS/POLYCLINIC ADMINISTRATORS ONLY ****

Here is another list of decisions made by hospital administrators in some areas. For each one, please tell me if you make that decision personally. Here is the first one...

	(ROTATE LIST)	DO	DO NOT	UNSURE (DNR)
39.	Allocate budget of hospital/clinic	55%	45%	*
40.	Borrow money (for example, to purchase equipment/supplies)	39%	59%	3%
41.	Build new extensions to the facility	40%	57%	3%
42.	Renovate facility	72%	28%	*
43.	Change type of procedures offered	61%	39%	*
44.	Change reimbursement system	48%	52%	*

(END ROTATION)

And --

45. Which of these do you think the hospital or clinic would most benefit from if you were able to do personally? **(DO NOT READ LIST)**

Allocate budget	20%
Borrow money	3%
Build	2%
Renovate	3%
Change procedures . . .	7%
Change reimbursement system	48%
OTHER **(DNR)**	7%
UNSURE **(DNR)**	12%

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**** ASK OF DOCTORS/NURSES/HOSPITAL OR POLYCLINIC ADMINISTRATORS ****

46. What is the percentage of unfilled positions at your facility?

None	46%
Less than 20%	14%
20% or more	12%
Unsure	28%

IF ANY PERCENT GIVEN, THEN ASK:

47. And, are these positions mostly for -- **(ROTATE)** -- • doctors, • nurses, • medical technicians, or • cleaners and non-medical personnel?

Doctors	10%
Nurses	24%
Medical technicians	24%
Non-medical	1%
OTHER **(SPECIFY)** _____	1%
UNSURE **(DNR)**	40%

Now, thinking about how your facility is financed --

48. Is your facility financed more by -- **(ROTATE)** --

- direct funding from the health authority,
- direct funding from the ministry of health,
- insurance funding through various insurance funds,
- privately financed,
- financed through an enterprise,
- a combination of direct health authority and insurance, OR
- a combination of direct health authority, insurance and private funding?

Health authority **(TO 52)**	39%
Ministry of Health **(TO 52)**	14%
Insurance **(TO 49-51)**	3%
Private **(TO 49-51)**	5%
Financed through enterprise **(TO 52)**	6%
Combination two **(TO 49-51)**	14%
Combination three **(TO 52)**	5%
NONE OF THESE **(DNR) (TO 52)**	3%
UNSURE/REFUSED **(DNR) (TO 52)**	11%

IF "INSURANCE," "PRIVATE" OR "COMBINATION OF THE TWO" THEN ASK:

49. What percentage of your funding is through insurance?

None	10%
Less than 30%	18%
30% or more	17%
Unsure	55%
Not asked	*

(CONTINUE TO 50)

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** IF POLYCLINIC **

50-1. How do you receive reimbursement for services? Is it -- ● according to the procedures performed, ● per patient served, OR ● per capita plus a specific per procedure fee?

Per procedure	4%
Per patient served	7%
Both	4%
Fixed Salary	34%
UNSURE (DNR)	50%

** IF HOSPITAL **

50-2. How do you receive reimbursement for services? Is it -- ● per hospitalized patient according to diagnosis, ● by the number of beds, ● per length of stay in hospital, OR ● by a negotiated budget?

Per hospitalized patients	5%
Number of beds	3%
Per length of stay	1%
Negotiated budget	27%
COMBINATION (DNR)	4%
UNSURE (DNR)	60%

---

51. And, if your facility received all its financing through insurance, would this be better, worse or about the same?

Better	20%
Worse	28%
About the same	11%
UNSURE (DNR)	42%

** ASK OF EVERYONE **

In some countries, such as France, Germany and the Netherlands, the government pays for health care by contributing to insurance companies, instead of contributing directly to the providers of the services, like hospitals and polyclinics. The providers are private and can make all their own decisions.

52. Would you favor or oppose instituting a similar system here in Russia?

IF CHOICE IS MADE, ASK:
And do you strongly (Favor/Oppose) or somewhat (Favor/Oppose)?

Favor/strongly	18%
Favor/somewhat	39%
UNSURE (DNR)	21%
Oppose/somewhat	9%
Oppose/strongly	13%

Still thinking about this --

53. Do you believe that under this system, where your facility is private and can make its own decisions but receives no direct funding from the state, that your facility would provide better care, worse care, or would it make no difference?

Better	38%
Worse	18%
No difference	25%
UNSURE (DNR)	20%

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And --

54. Under this system, do you believe that costs per patient would increase, decrease, or stay about the same?

Increase	64%
Decrease	4%
About the same	11%
UNSURE (DNR)	22%

Now, in some countries, such as Great Britain, Sweden, Denmark and Finland, the government owns hospitals and clinics, but the facilities operate themselves and control all decisions. The state pays the facilities on a per capita basis or by negotiating contracts each year.

55. Would you favor or oppose instituting a similar system here in Russia?

IF CHOICE IS MADE, ASK: And do you strongly (Favor/Oppose) or somewhat (Favor/Oppose)?

Favor/strongly	40%
Favor/somewhat	38%
UNSURE (DNR)	15%
Oppose/somewhat	5%
Oppose/strongly	3%

Still thinking about this --

56. Do you believe that under this system that your facility would provide better care, worse care, or would it make no difference?

Better	61%
Worse	5%
No difference	16%
UNSURE (DNR)	18%

Now, thinking about patients' choice in facilities --

57. Can patients outside your geographic area choose to go to your facility?

Yes	94%
No	5%
UNSURE (DNR)	1%

And --

58. Should patients be able to have a choice as to which facility to use without any extra cost?

Yes	83%
No	14%
UNSURE (DNR)	3%

And --

59. Should patients be able to have a choice as to which doctor to go to?

Yes	98%
No	2%
UNSURE (DNR)	1%

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60. Are you employed in a polyclinic or a hospital?

Polyclinic (TO 61-63)	56%
Hospital (TO 64-65)	34%
OTHER (DNR) SPECIFY (TO 66)	11%
UNSURE/REFUSED (DNR)(TO 66)	*

IF POLYCLINIC THEN ASK:

61. Is your polyclinic attached to a business, factory or enterprise?

Yes/attached	33%
No/not attached	67%
UNSURE (DNR)	*

(CONTINUE TO 62)

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62. How many doctors does your clinic have in all?

15 or less	29%
16 - 30	21%
31 - 99	21%
100 or more	6%
Dk/no answer	24%

(CONTINUE TO 63)

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63. And, how many of these are specialists?

Therapist	16%
Dentist	7%
Other specialist	29%
Administrator	12%
Nurse	20%
Medical attendant	6%
Pharmacist	10%

IF HOSPITAL THEN ASK:

64. Does your hospital have emergency facilities or not?

Yes/emergency	68%
No/no emergency	33%
UNSURE (DNR)	*

(CONTINUE TO 65)

---

65. And, how many beds does your hospital have?

100 or less	15%
101 - 200	21%
201 - 500	22%
More than 500	29%
Dk/no answer	13%

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(ASK OF EVERYONE **)**

Now, just a few final questions for statistical purposes only --

66. Gender **(BY OBSERVATION)**

Male	32%
Female	68%

67. How old are you?

18-24	5%
25-29	11%
30-34	14%
35-39	18%
40-44	20%
45-54	23%
55-64	7%
65 and over	2%

68. What is your education? **(DO NOT READ, JUST RECORD)**

Some technical school	30%
Nursing school	*
Pharmaceutical school	7%
College graduate	*
Doctor, MD	1%
PhD	*

69. What was your monthly average income over the past two or three months after taxes? (Rubles per month)

30,000 OR LESS	1%
30,001-40,000	2%
40,001-50,000	2%
50,001-70,000	5%
70,001-100,000	19%
100,001-200,000	36%
200,001-300,000	22%
300,001-400,000	8%
400,001 and over	5%
REFUSE **(DNR)**	1%
UNSURE/NO OPINION **(DNR)**	1%

**** ASK OF DOCTORS ONLY ****

70. What is the average amount of additional income you earn by taking in patients from outside your area and/or emergency patients? (Rubles per year)

Less than 10,000	2%
10,001-50,000	*
50,001-100,000	2%
100,001-250,000	2%
Over 250,000	2%
NOTHING **(DNR)**	80%
REFUSED **(DNR)**	7%
UNSURE **(DNR)**	3%

71. CODE POSITION

Practicing doctor (TO 72)	16%
Dentist	7%
Other Specialist	29%
Nurse (TO 74)	20%
Pharmacist or in pharmaceutical industry (TO 73)	10%
Health care bureaucrat administrator (TO 74)	12%

IF PRACTICING DOCTOR, THEN ASK:

72. And, are you a general practitioner or a specialist?

General	16%
Specialist	29%
ADMINISTRATOR (RECODE ABOVE)	12%
UNSURE/REFUSED (DNR) . . .	*

IF IN PHARMACEUTICAL INDUSTRY, THEN ASK:

Thinking about your workplace --

73. Are you employed by a private sector company, a state-run/ public sector company, or is it in a state of transition from public to private at this time?

Private	7%
Public	71%
Transition	11%
NEITHER(DNR)	*
UNSURE (DNR)	11%

---

57. За последние 12 месяцев пытались ли Вы делать что-либо из того что я перечислю, чтобы улучить или сохранить свое здоровье? */ЗАЧИТАЙТЕ. ВОЗМОЖНО НЕСКОЛЬКО ВЫБОРОВ/*

01. Стал меньше употреблять алкоголя или совсем перестал его употреблять
02. Бросил курить
03. Начал заниматься физическими упражнениями или увеличил количество своих занятий
04. Начал следить за качеством своего питания
05. Соблюдал диету, чтобы снизить вес
06. Регулярно измерял давление
07. Проверял уровень холестерина
08. Принимал витамины
09. Посещал семинары или лекции по охране здоровья
10. Читал медицинскую литературу
(98) Другое */ЧТО ИМЕННО/* _____
(99) Затрудняюсь ответить, отказ от ответа */НЕ ЧИТАТЬ/*

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58. Скажите, пожалуйста, пострадало ли здоровье у Вас лично, кого-либо из членов Вашей семьи или близких знакомых за последние два года от загрязнения окружающей среды или Вы не знаете таких фактов?

(1) Да -->*К ВОПРОСУ 59*
(2) Нет -->*К ВОПРОСУ 60*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 59*

---

59. Скажите, пожалуйста, от какого рода загрязнений пострадали Вы или кто-либо из тех, кого Вы лично близко знаете? */ЗАЧИТАЙТЕ/*

1. От загрязнения воздуха
2. От химических продуктов, химического производства
3. Загрязнения воды
4. Радиации
5. Пестицидов в продуктах
(8) От чего-либо другого */ЧЕГО ИМЕННО/*_____
(9) Затрудняюсь ответить/нет мнения

---

60. Считаете ли Вы местность, в которой Вы живете, очень вредной для Вашего здововья из-за сильного загрязнения окружающей среды, довольно вредной, не особенно вредной или не считаете ее вредной совсем? */НЕ ЧИТАТЬ/*

(1) Очень вредная
(2) Довольно вредная
(3) Не очень вредная
(4) Совершенно безвредная
(9) Затрудняюсь ответить/нет мнения

---

61. За последние два года как часто Вы находились в состоянии стресса или сильного нервного напряжения? */ЗАЧИТАЙТЕ/*

1. Практически ежедневно -->*К ВОПРОСУ 62*
2. Несколько раз в неделю -->*К ВОПРОСУ 62*
3. Несколько раз в месяц -->*К ВОПРОСУ 62*
4. Несколько раз в год -->*К ВОПРОСУ 62*
5. Никогда не испытывал стресса -->*К ВОПРОСУ 63*
(9) Затрудняюсь ответить -->*К ВОПРОСУ 63*

---

62. За последние 12 месяцев приходилось ли Вам обращаться за помощью к врачу, чтобы справиться со стрессовым состоянием?

(1) Да
(2) Нет
(9) Затрудняюсь ответить

---

63. Скажите, пожалуйста, имеете ли Вы какие-нибудь льготы на приобретение лекарств или нет?

(1) Да *-->К ВОПРОСУ 64*
(2) Нет *-->К ВОПРОСУ 65*
(9) Затрудняюсь ответить *-->К ВОПРОСУ 65*

---

64. За последние 12 месяцев случалось ли Вам сталкиваться с трудностями при получении лекарств на льготных условиях, которые Вам полагаются?

ЕСЛИ ДА, УТОЧНИТЕ: С какими именно трудностями Вы сталкивались? */ЗАЧИТАЙТЕ/*

1. Врач не хотел выписывать рецепт на приобретение лекарств на льготных условиях
2. Аптека не хотела выдавать Вам лекарство на льготных условиях
3. Лекарства, которое Вы искали, не было в аптеках

(8) Другое */ЧТО ИМЕННО/* _____
(7) Не сталкивался ни с каким трудностями
(9) Затрудняюсь ответить

---

65. Скажите, пожалуйста, где Вы обычно покупаете лекарства? */ЗАЧИТАЙТЕ/*

1. В государственной аптеке
2. В коммерческой аптеке
3. Срук, на черном рынке
4. Достаю через знакомых

(8) Другое */ГДЕ ИМЕННО/* _____
(9) Затрудняюсь ответить

---

66. Если за последние два года Вы сами или кто-либо из Ваших близких лежали в больнице, то приходилось ли Вам или кому-либо из Ваших родных во время пребывания в больнице самому доставать или платить за лекарства, которые Вам прописали? */НЕ ЧИТАТЬ/*

(1) Не лежал в больнице
(2) Да, приходилось доставать
(3) Нет, не приходилось доставать лекарств
(9) Затрудняюсь ответить

СОЦИАЛЬНО-ДЕМОГРАФИЧЕСКИЕ СВЕДЕНИЯ

И, наконец, несколько заключительных вопросов

150. Сейчас Вы: *(ЗАЧИТЫВАЙТЕ ОТВЕТЫ, ПОКА НЕ ПОЛУЧИТЕ "Да")*

1. Работаете *(УТОЧНИТЕ, ПОДЧЕРКНУВ НУЖНОЕ)* /постоянно, временно, кооператор, "индивидуал", работающий пенсионер, работающий инвалид/ *-->К ВОПРОСУ 150А*
2. Временно не работаете: в декретном отпуске; в отпуске без сохранения содержания; в отпуске по уходу за ребенком *-->К ВОПРОСУ 152*
3. Неработающий пенсионер, инвалид *-->К ВОПРОСУ 152*
4. Не работаете и занимаетесь домашним, подсобным хозяйством; воспитываете детей *-->К ВОПРОСУ 152*
5. Не работаете /безработный/, но ищите работу *-->К ВОПРОСУ 152*
6. Учитесь в дневном учебном заведении *-->К ВОПРОСУ 152*
7. Военнослужащий *-->К ВОПРОСУ 152*

(8) Другие виды занятости (КАКИЕ)_____ *-->К ВОПРОСУ 150А*

ЕСЛИ ОТМЕЧЕН ПУНКТ 1 или 8 В ВОПРОСЕ 150, ТО СПРОСИТЕ:

А/. К какой категории Вы относитесь? Вы:

1. Рабочий
2. ИТР
3. Интеллигент, не занятый на производстве
4. Служащий
5. Врач, мед.сестра, работник медицинской сферы
6. Крестьянин, фермер

(8) Другое /уточните, кто именно/_____

В/. Каково Ваше служебное положение? Вы:

1. Руководитель организации или его заместитель
2. Руководитель подразделения
3. Рядовой работник

151. Скажите, Вы работаете в: */ЗАЧИТАЙТЕ/*

1. Частной или кооперативной фирме, организации
2. Государственной организации, предприятии
3. В организации, которая находится в стадии перехода из государственной в частную

(4) Ничего из перечисленного

(9) Затрудняюсь ответить

СПРОСИТЕ ВСЕХ

152. ПОЛ РЕСПОНДЕНТА

(1) Мужской

(2) Женский

153. Сколько лет Вам исполнилось в последний день рождения?

!_____! (напишите)

154. Ваше образование в настоящее время? */НЕ ЧИТАТЬ/*

(1) 7 классов и меньше

(2) Незаконченная средняя школа

(3) Законченная средняя школа, в том числе ПТУ со средним образованием

(4) Среднее специальное образование (техникум и т.д.)

(5) Незаконченное высшее (не менее 3-х курсов)

(6) Высшее

---

155. Сколько взрослых членов семьи старше 18 лет, включая Вас, живет вместе с Вами?

!_____!

156. Скажите, есть ли в Вашей семье дети до 18 лет?

(1) Да -->*К ВОПРОСАМ 157*

(2) Нет -->*К ВОПРОСУ 158*

(9) Затрудняюсь ответить -->*К ВОПРОСУ 158*

---

157. Были ли сделаны прививки от инфекционных заболеваний Вашим детям? */НЕ ЧИТАТЬ/*

(1) Да, сделаны все прививки

(2) Да, сделаны почти все, или некоторые прививки

(2) Нет, не сделано никаких прививок

(9) Затрудняюсь ответить, не знаю

483

158. Как Вы, возможно, знаете, взрослым людям тоже необходимы прививки, чтобы избежать некоторых инфекционных заболеваний. За последние 5 лет были ли сделаны какие-нибудь прививки Вам лично?

(1) Да -->*К ВОПРОСУ 160*
(2) Нет -->*К ВОПРОСУ 159*
(9) Затрудняюсь ответить -->*К ВОПРОСУ 160*

---

159. Почему Вы не делали прививок от инфекционных заболеваний? */НЕ ЧИТАТЬ. КОДИРУЙТЕ СО СЛОВ/*

(1) Не знал, что они необходимы
(2) Не знал, где их можно сделать
(3) Врачи не рекомендовали мне делать этого
(4) Не доверяю врачам, боюсь заразиться в процессе прививки
(5) Медицинское учреждение отказалось делать мне прививку
(8) Другое */ПОЧЕМУ ИМЕННО/* _____
(9) Затрудняюсь ответить

Мы хотели бы при обработке данных этого опроса учесть уровень доходов населения

160. Скажите, пожалуйста, каков был Ваш *личный* доход в прошлом месяце до вычета каких-либо налогов?

!_____! ВСЕГО РУБЛЕЙ В ПРОШЛОМ МЕСЯЦЕ
(9999998) Отказ от ответа
(9999999) Затрудняюсь ответить

161. Скажите, пожалуйста, если учитывать все виды дохода всех членов семьи - зарплату, пенсии, стипендии, пособия на детей, алименты и т.п.- каков был общий доход Вашей семьи в прошлом месяце, т.е. в апреле, до вычета каких-либо налогов? */УБЕДИТЕСЬ, ЧТО УЧТЕНЫ ВСЕ ВИДЫ ДОХОДОВ ВСЕХ ЧЛЕНОВ СЕМЬИ/*

!_____! ВСЕГО РУБЛЕЙ В ПРОШЛОМ МЕСЯЦЕ
(9999998) Отказ от ответа
(9999999) Затрудняюсь ответить

ЗАЧИТАЙТЕ РЕСПОНДЕНТУ: Это все вопросы, которые мы хотели Вам задать. Если у Вас, в свою очередь, есть вопросы ко мне, я постараюсь на них ответить. Вы можете позвонить нам и позже. Напоминаю наш телефон в Москве: 128-56-01. Благодарим за помощь в работе!

ИНТЕРВЬЮЕР: НАПИШИТЕ ЧЕТКО ВАШУ ФАМИЛИЮ, ИМЯ, ОТЧЕСТВО

_____

Ручательство интервьюера: Я удостоверяю, что опрос проведен мною в соответствии с Инструкцией методом личного интервью с отобранным по Инструкции респондентом.

Номер интервьюера !_____! Подпись

_____

Дата проведения интервью: _____ число май месяц 1994 года

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For Doctors

Код	Ввод

Институт сравнительных социальных исследований
117218, Москва, ул. Кржижановского, 24/35, к. 5
тел. 095/128-56-01

Документ ЦЕССИ/С94054
Анкета N _____
Город/село опроса
_____

Медицинское обслуживание в России. Опрос медицинских работников

****

ИНТЕРВЬЮЕР, ДАЛЕЕ ВАМ В СООТВЕТСТВИИ С ИНСТРУКЦИЯМИ К НЕКОТОРЫМ ВОПРОСАМ ПРИДЕТСЯ МЕНЯТЬ ПОРЯДОК ЧТЕНИЯ АЛЬТЕРНАТИВ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА, С КОТОРЫМ ВЫ ГОВОРИТЕ. ОТМЕТЬТЕ ЗДЕСЬ КАКОГО ПОРЯДКА ЧТЕНИЯ ВЫ БУДЕТЕ ПРИДЕРЖИВАТЬСЯ ДЛЯ ДАННОГО РЕСПОНДЕНТА. ДЛЯ ПЕРВОГО РЕСПОНДЕНТА ПОРЯДОК ЧТЕНИЯ ВСЕГДА ТАКОЙ КАК НАПЕЧАТАН В АНКЕТЕ

1. КАК НАПЕЧАТАН В АНКЕТЕ 2. ОБРАТНЫЙ ПОРЯДОК

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1. Насколько Вы удовлетворены состоянием медицинского обслуживания в России - полностью удовлетворены, частично удовлетворены, частично не удовлетворены или полностью не удовлетворены? */НЕ ЧИТАТЬ/*

   (1) Полностью удовлетворен -->*К ВОПРОСУ 4*
   (2) Частично удовлетворен -->*К ВОПРОСУ 4*
   (3) Частично не удовлетворен -->*К ВОПРОСУ 2*
   (4) Полностью не удовлетворен -->*К ВОПРОСУ 2*
   (9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 4*

ЕСЛИ "ЧАСТИЧНО НЕ УДОВЛЕТВОРЕН" ИЛИ "ПОЛНОСТЬЮ НЕ УДОВЛЕТВОРЕН" в В.1, СПРОСИТЕ:

2. Кто, по Вашему мнению, в наибольшей степени в ответе за существующие в настоящее время проблемы системы здравоохранения в России? *(НЕ ЧИТАТЬ. КОДИРУЙТЕ СО СЛОВ ОДИН ВЫБОР)*

	Виноват в наибольшей степени
Старая советская система, коммунисты	(01)
Реформаторы в сегодняшнем правительстве	(02)
Запад, западные страны	(03)
Медицинские учебные учреждения	(04)
Администрация больниц	(05)
Врачи	(06)
Фармацевтическая промышленность	(07)
Министерство здравоохранения	(08)
Комбинация из перечисленного */НЕ ЧИТАТЬ/*	(97)
Другое */КТО ИМЕННО/* _____	(98)
Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*	(99)

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3. Скажите, пожалуйста, какая одна основная причина того, что Вы не полностью удовлетворены существующим положением медицинского обслуживания в России. А также скажите как, по Вашему мнению, можно было бы исправить или улучшить систему нашего здравоохранения? *(ЗАПИШИТЕ ДОСЛОВНО ОТВЕТ РЕСПОНДЕНТА. ПОСТАРАЙТЕСЬ ПОЛУЧИТЬ КАК МОЖНО БОЛЕЕ КОНКРЕТНЫЙ ОТВЕТ)*

ЕСЛИ ОТВЕТ НЕ ЯСЕН, УТОЧНИТЕ: Что Вы имеете ввиду? Расскажите, пожалуйста, подробней об этом.

!_____!

!_____!

!_____!

485

СПРОСИТЕ ВСЕХ

Еще один вопрос о системе здравоохранения в России сегодня

4. Скажите, пожалуйста, в настоящее время Вы испытываете меньше беспокойства относительно состояния медицинского обслуживания в России, чем 10 лет назад, больше беспокойства или примерно такое же как 10 лет назад? */НЕ ЧИТАТЬ/*

   (1) Меньше беспокойства
   (2) Больше беспокойства
   (3) Также, как и раньше
   (9) Затрудняюсь ответить/нет мнения

Теперь поговорим о больницах и поликлиниках в Вашем районе

5. В целом как Вы считаете, персонал медицинских учреждений в Вашем районе очень хорошо обучен работать с последними медицинскими технологиями; хорошо обучен, но многим следовало бы получить дополнительную подготовку в определенных областях; в целом персонал подготовлен, но большинству нужно было бы пройти обучение основным навыкам или персонал в целом некомпетентен? */НЕ ЧИТАТЬ/*

   (1) Очень хорошо обучены
   (2) Хорошо обучены
   (3) В целом подготовлен
   (4) В целом некомпетентны
   (9) Затрудняюсь ответить/нет мнения

Теперь поговорим о местных аптеках

6. В целом как Вы считаете, работники аптек в Вашей местности очень хорошо обучены работать с новейшими медицинскими технологиями; хорошо обучены, но многим следовало бы получить дополнительную подготовку в определенных областях; в целом подготовлены, но большинству нужно было бы пройти обучение основным навыкам или в целом некомпетентны? */НЕ ЧИТАТЬ/*

   (1) Очень хорошо обучены
   (2) Хорошо обучены
   (3) В целом подготовлены
   (4) В целом некомпетентны
   (9) Затрудняюсь ответить/нет мнения

Следующий вопрос о наличии лекарств в России сегодня

7. Исходя из Вашего опыта, как Вы считаете, обеспеченность лекарствами за последние 12 месяцев, стала лучше, стала хуже или осталась на том уровне? */НЕ ЧИТАТЬ/*

   (1) Стала лучше
   (2) Стала хуже
   (3) Осталась на том уровне
   (9) Затрудняюсь ответить/нет мнения

---

8. Скажите, пожалуйста, Вы видели, читали или слышали что-либо о новом законе об обязательном медицинском страховании, вступившем в силу в прошлом году, или нет?

   (1) Да -->*К ВОПРОСАМ 9-10*
   (2) Нет -->*К ВОПРОСУ 11*
   (9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 11*

---

9. Вспомните, пожалуйста, о том, что Вы видели, читали или слышали о новом законе об обязательно медицинском страховании и скажите мне, считаете ли Вы, что новая правительственная программа по медицинскому страхованию улучшит медицинское обслуживание в нашей стране или ухудшит его?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы думаете, что новая программа существенно улучшит/ухудшит медицинское обслуживание или лишь несколько улучшит/ухудшит?

(1) Существенно улучшит
(2) Несколько улучшит
(3) Несколько ухудшит
(4) Существенно ухудшит
(5) Ничего не изменится
(9) Затрудняюсь ответить/нет мнения

---

10. Какое влияние, на Ваш взгляд, окажет новый закон о медицинском страховании на Вас и на Ваши коллег по профессии - большое влияние, небольшое влияние или не окажет никакого влияния? */НЕ ЧИТАТЬ/*

(1) Большое влияние
(2) Небольшое влияние
(3) Не окажет никакого влияния
(9) Затрудняюсь ответить/нет мнения

---

11. Представьте себе, что весь Ваш доход составляет 100%. Скажите, пожалуйста, какой процент из Вашего общего дохода составляет доход от услуг, которые Вы оказываете частным образом, дополнительно к Вашей основной зарплате?

!_____! */ЗАПИШИТЕ ЧАСТЬ ДОХОДА В ПРОЦЕНТАХ/*
(997) Отказ от ответа */НЕ ЧИТАТЬ/*
(999) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

Теперь мне бы хотелось зачитать Вам список некоторых медицинских процедур, которые могут быть однажды исключены из понятия "базового, жизненно необходимого медицинского обслуживания" и за которое государство, возможно, не сможет больше платить. Пожалуйста, скажите мне поводу каждой из этих видов медицинской помощи, считаете ли Вы, что государство должно включить этот вид помощи в пакет базового страхового медицинского обслуживания или пациенты должны согласиться платить дополнительно за этот вид помощи. Первая из них... */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

		Должно платить правительство	Должен платить пациент	Затрудняюсь ответить */НЕ ЧИТАТЬ/*
12.	Психиатрическая помощь, терапия	1	2	(9)
13.	Аборты	1	2	(9)
14.	Контрацепция, планирование семьи	1	2	(9)
15.	Лечение алкоголизма	1	2	(9)
16.	Профилактическое обследование	1	2	(9)
17.	Детская терапия	1	2	(9)
18.	Оптометрическое обследование, очки	1	2	(9)

Следующий вопрос об образовании населения в области здравоохранения, которое пытается проводить государство

19. Скажите, пожалуйста, Вы лично участвуете в каких-либо программах по образованию населения в области охраны здоровья населения или нет?

    (1) Да -->*К ВОПРОСАМ 20*
    (2) Нет -->*К ВОПРОСУ 21*
    (9) Затрудняюсь ответить -->*К ВОПРОСУ 21*

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20. По каким медицинским проблемам проводилась образовательная программа, в которой Вы участвовали? */ЗАЧИТАЙТЕ/*

	Упомянуто	Не упомянуто
1. По проблемам детского здоровья	1	2
2. По проблемам здоровья женщин	1	2
3. По проблемам здоровья стариков	1	2
4. По проблемам несчастных случаев	1	2
5. По проблемам профилактики и пропаганды здорового образа жизни, например, вреда курения или употребления алкоголя	1	2

СПРОСИТЕ ВСЕХ

Еще один вопрос о существующей системе медицинского обслуживания

21. Считаете ли Вы, что существующая система медицинского обслуживания отвечает нуждам россиян или нет?

    (1) Да -->*К ВОПРОСАМ 23*
    (2) Нет -->*К ВОПРОСУ 22*
    (9) Затрудняюсь ответить -->*К ВОПРОСУ 22*

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22. Скажите, пожалуйста, как можно конкретнее, какие побудительные стимулы необходимы работникам медицины и администрации медицинских учреждений, чтобы обеспечить лучшее удовлетворение потребностей россиян в медицинской помощи? *(ЗАПИШИТЕ ДОСЛОВНО ОТВЕТ РЕСПОНДЕНТА. ПОСТАРАЙТЕСЬ ПОЛУЧИТЬ КАК МОЖНО БОЛЕЕ КОНКРЕТНЫЙ ОТВЕТ)*

!_____!

!_____!

!_____!

!_____!

СПРОСИТЕ ВСЕХ

23. Скажите, пожалуйста, считаете ли Вы, что конкуренция среди медицинских учреждений, то есть среди больниц, поликлиник, аптек и фармацевтических предприятий, будет способствовать развитию более качественного медицинского обслуживания за меньшую цену?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы полностью уверены в своем мнении или лишь частично уверены?

(1) Полностью уверен, что да
(2) Частично уверен, что да
(3) Частично уверен, что нет
(4) Полностью уверен, что нет
(9) Затрудняюсь ответить/нет мнения

---

24. Скажите, пожалуйста, Вы за или против того, чтобы официально позволить пациентам платить врачам и медицинским сестрам дополнительно за определенные услуги или особые удобства?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы полностью уверены в своем мнении или лишь частично уверены?

(1) Полностью уверен, что да
(2) Частично уверен, что да
(3) Частично уверен, что нет
(4) Полностью уверен, что нет
(9) Затрудняюсь ответить/нет мнения

Пожалуйста, скажите мне, обладает ли Ваше медицинское учреждение правом принимать решения по каждому из вопросов, которые я Вам перечислю, или принятие таких решений находится в руках вышестоящих организаций. Первое из них... */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

	Обладает	Не обладает	Затрудняюсь ответить
25. Прием персонала на работу	1	2	(9)
26. Определение размера зарплат и условий труда	1	2	(9)
27. Покупка оборудования	1	2	(9)
28. Выбор фирмы и марки приобретаемого оборудования	1	2	(9)
29. Решение о том, какого пациента принимать, а какого нет	1	2	(9)
30. Решение о том, какие услуги предоставлять и какие отделения иметь	1	2	(9)
31. Аренда помещения или продажа товаров третьей стороне	1	2	(9)
32. Увольнение персонала	1	2	(9)
33. Размещение средств, заработанных от лечения частных пациентов или пациентов из других районов страны	1	2	(9)
34. Покупка лекарств	1	2	(9)
35. Выборы глав.врача	1	2	(9)
36. Установление режима работы больницы и срока пребывания пациентов в больнице	1	2	(9)

37. Пожалуйста, вспомните о тех решениях, которые Ваше медицинское учреждение не может принимать самостоятельно, и скажите мне, если бы Ваше медицинское учреждение могло получить право принимать решения по одному из вопросов, о которых мы говорили, что бы Вы выбрали в первую очередь? */НЕ ЧИТАТЬ. ВОЗМОЖЕН ОДИН ОТВЕТ В КОЛОНКЕ В.37/*

38. *КОГДА ВЫБОР СДЕЛАН, СПРОСИТЕ:* А что Вы выбрали бы во вторую очередь? */НЕ ЧИТАТЬ. ВОЗМОЖЕН ОДИН ОТВЕТ В КОЛОНКЕ В.38/*

	В.37 В первую очередь	В.38 Во вторую очередь
Прием персонала на работу	(01)	(01)
Определение зарплат и условий труда	(02)	(02)
Покупка оборудования	(03)	(03)
Выбор фирмы и марки оборудования	(04)	(04)
Решение о том, какого пациента принимать, а какого нет	(05)	(05)
Решение о том, какие услуги предоставлять и какие отделения иметь	(06)	(06)
Аренда помещения или продажа товаров третьей стороне	(07)	(07)
Увольнение персонала	(08)	(08)
Размещение средств, заработанных от лечения частных пациентов или пациентов из других районов страны	(09)	(09)
Покупка лекарств	(10)	(10)
Выборы глав.врача	(11)	(11)
Установление режима работы больницы и срока пребывания пациентов в больнице	(12)	(12)
Другое */ЗАПИШИТЕ/* _____	(98)	(98)
Затрудняюсь ответить/нет мнения	(99)	(99)

СПРОСИТЕ АДМИНИСТРАТОРОВ БОЛЬНИЦ И ПОЛИКЛИНИК, ГЛАВ.ВРАЧЕЙ

Сейчас я собираюсь зачитать Вам другой список решений, которые принимаются администраторами некоторых больниц и поликлиник. Скажите мне, пожалуйста, по поводу каждого из таких решений, приходится ли Вам лично принимать такого рода решения или нет. Первое из них... */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

	Приходится	Не приходится	Затрудняюсь ответить
39. Распределение бюджета больницы, поликлиники	1	2	(9)
40. Получение займов, кредитов (например, для приобретения оборудования, другого оснащения)	1	2	(9)
41. Строительство новых корпусов	1	2	(9)
42. Ремонт помещений	1	2	(9)
43. Изменение типа оказываемых услуг	1	2	(9)
44. Изменений системы оплаты труда	1	2	(9)

45. Как Вы считаете, какое одно из решений, на Ваш взгляд, было бы наиболее выгодно для Вашего медицинского учреждения передать на Ваше личное рассмотрение? */НЕ ЧИТАТЬ. ВОЗМОЖЕН ОДИН ВЫБОР/*

(1) Размещение средств
(2) Заем средств
(3) Строительство
(4) Реконструкция, ремонт
(5) Изменить процедуры лечения
(6) Изменение системы оплаты труда
(8) Другое */ЧТО ИМЕННО/*_____
(9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

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СПРОСИТЕ ВСЕХ

46. Если принять все рабочие места в Вашем медицинском учреждении за 100%, скажите, пожалуйста, какой процент рабочих мест в Вашем медицинском учреждении вакантен в настоящее время, то есть эти рабочие места пустуют?

!_____! */ЗАПИШИТЕ В ПРОЦЕНТАХ/ -->К ВОПРОСУ 47*

(000) Все места заполнены */НЕ ЧИТАТЬ/ -->К ВОПРОСУ 48*

(999) Затрудняюсь ответить */НЕ ЧИТАТЬ/ -->К ВОПРОСУ 48*

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47. Скажите, пожалуйста, какие должности в основном не заполнены и пустуют в Вашем медицинском учреждении - */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА. ВОЗМОЖЕН ОДИН ОТВЕТ/*

1. Должность врача
2. Должность медицинской сестры
3. Должность уборщицы
4. Другой немедицинский персонал

(8) Другие */КТО ИМЕННО/*_____

(9) Затрудняюсь ответить/нет мнения

Теперь о финансировании медицинских учреждений

48. Скажите, пожалуйста, как финансируется медицинское учреждение, в котором Вы работаете? */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА. ВОЗМОЖЕН ОДИН ВЫБОР/*

01. Прямое финансирование от государства *-->К ВОПРОСУ 50.1*
02. Прямое финансирование от Министерства здравоохранения *-->К ВОПРОСУ 50.1*
03. Из страховых взносов через различные страховые фонды *-->К ВОПРОСУ 49*
04. От частных лиц или частных организаций *-->К ВОПРОСУ 49*
05. Финансирование от предприятий *-->К ВОПРОСУ 50.1*
06. Частично прямое государственное финансирование, частично из страховых взносов *-->К ВОПРОСУ 49*
07. Частично прямое государственное финансирование, частично из страховых взносов, и частично от частных взносов *-->К ВОПРОСУ 50.1*

(97) Ничего из перечисленного */НЕ ЧИТАТЬ/ -->К ВОПРОСУ 50.1*

(98) Другое */ЧТО ИМЕННО/* _____ *-->К ВОПРОСУ 50.1*

(99) Затрудняюсь ответить, отказ от ответа */НЕ ЧИТАТЬ/ -->К ВОПРОСУ 50.1*

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49. Если принять весь бюджет Вашего медицинского учреждения за 100%, какой процент от общего бюджета составляют средства от страховых взносов?

!_____! */ЗАПИШИТЕ В ПРОЦЕНТАХ/*

(999) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

ЕСЛИ РАБОТАЕТ В ПОЛИКЛИНИКЕ. ЕСЛИ НЕТ ПЕРЕХОДИТЕ К В.50.2

50.1. Как оплачивается Ваш труд - в зависимости от вида оказываемых услуг; от количества пациентов или за каждого пациента и плюс плата за конкретные процедуры, или постоянная зарплата вне зависимости от чего-либо? */НЕ ЧИТАТЬ/*

(1) В зависимости от вида оказываемых услуг -->*К ВОПРОСУ 51*
(2) От количества пациентов -->*К ВОПРОСУ 51*
(3) За каждого пациента и плюс плата за конкретные процедуры -->*К ВОПРОСУ 51*
(4) Зарплата вне зависимости от чего-либо -->*К ВОПРОСУ 51*
(8) Другое */ЧТО ИМЕННО/*_____ -->*К ВОПРОСУ 51*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 51*

ЕСЛИ РАБОТАЕТ В БОЛЬНИЦЕ. ЕСЛИ НЕТ ПЕРЕХОДИТЕ К В.51

50.2. Как оплачивается Ваш труд - в зависимости от количества пациентов; по числу больничных коек; в зависимости от времени пребывания пациента в больнице или из постоянного бюджета? */НЕ ЧИТАТЬ/*

(1) В зависимости от количества пациентов
(2) В зависимости от числа больничных коек
(3) От времени пребывания пациента в больнице
(4) Из постоянного бюджета
(8) Другое */ЧТО ИМЕННО/*_____
(7) Комбинация из перечисленного
(9) Затрудняюсь ответить/нет мнения

СПРОСИТЕ ВСЕХ

51. Если бы Ваше медицинское учреждение полностью финансировалось из страховых взносов, по Вашему мнению, это было бы лучше для Вашего медицинского учреждения, хуже или все было бы также, как сейчас? */НЕ ЧИТАТЬ/*

(1) Лучше
(2) Хуже
(3) Также как сейчас
(9) Затрудняюсь ответить/нет мнения

Как Вы, возможно, знаете, в некоторых странах, таких как Франция, Германия и Нидерланды, государство вкладывает средства в здравоохранение страны, перечисляя деньги не самим медицинским учреждениям - больницам и поликлиникам, а страховым компаниям. При этом сами медицинские учреждения являются частными и могут принимать все основные решения, касающиеся работы своего учреждения самостоятельно.

52. Скажите, пожалуйста, Вы были бы за или против введения подобной системы в России? */НЕ ЧИТАТЬ/*

КОГДА ВЫБОР СДЕЛАН, СПРОСИТЕ: Вы <u>полностью</u> за/против введения подобной системы в России или лишь <u>отчасти</u> за/против?

(1) Полностью за
(2) Отчасти за
(3) Отчасти против
(4) Полностью против
(9) Затрудняюсь ответить/нет мнения

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53. Как Вы считаете, при такой системе, когда Ваше медицинское учреждение станет платным и сможете принимать все важные решения самостоятельно, но не будет получать прямого финансирования от государства, Ваше медицинское учреждение сможет предоставлять услуги лучшего качества; худшего качества или это ничего не изменит? */НЕ ЧИТАТЬ/*

(1) Лучшего качества
(2) Худшего качества
(3) Также как сейчас, ничего не изменится
(9) Затрудняюсь ответить/нет мнения

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54. Как Вы считаете, при такой системе стоимость обслуживания одного пациента возрастет, снизится или останется такой же? */НЕ ЧИТАТЬ/*

(1) Возрастет
(2) Снизится
(3) Останется такой же
(9) Затрудняюсь ответить/нет мнения

Как Вы, возможно, знаете, в некоторых странах, таких как Великобритания, Швеция, Дания и Финляндия, больницы и поликлиники принадлежат государству, но медицинские учреждения работают самостоятельно и осуществляют контроль над всеми внутренними решениями. Государство выделяет постоянное финансирование медицинскому учреждению или возобновляет контракт каждый год.

55. Скажите, пожалуйста, Вы были бы за или против введения подобной системы в России? */НЕ ЧИТАТЬ/*

КОГДА ВЫБОР СДЕЛАН, СПРОСИТЕ: Вы полностью за/против введения подобной системы в России или лишь отчасти за/против?

(1) Полностью за
(2) Отчасти за
(3) Отчасти против
(4) Полностью против
(9) Затрудняюсь ответить/нет мнения

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56. Как Вы считаете, при такой системе Ваше медицинское учреждение сможет предоставлять услуги лучшего качества, худшего качества или это ничего не изменит? */НЕ ЧИТАТЬ/*

(1) Лучшего качества
(2) Худшего качество
(3) Также как сейчас, ничего не изменит
(9) Затрудняюсь ответить/нет мнения

Еще один вопрос о выборе пациентом медицинского учреждения, в котором он будет лечится

57. Считаете ли Вы, что пациент, живущий в другом месте страны - в другом городе, селе должен иметь право получить медицинскую помощь в Вашем медицинском учреждении?

(1) Да
(2) Нет
(9) Затрудняюсь ответить

---

58. Как Вы считаете, должен ли пациент иметь возможность выбирать в каком медицинском учреждении лечиться, не платя дополнительно?

(1) Да
(2) Нет
(9) Затрудняюсь ответить

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59. Как Вы считаете, должен ли пациент иметь возможность выбирать к какому врачу пойти лечится, или нет?

(1) Да
(2) Нет
(9) Затрудняюсь ответить

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60. Скажите, пожалуйста, в каком медицинском учреждении Вы работаете?

(01) В районной поликлинике -->*К ВОПРОСУ 61-62*
(02) В платной поликлинике -->*К ВОПРОСУ 61-62*
(03) В ведомственной поликлинике -->*К ВОПРОСУ 61-62*
(04) В поликлинике другого типа */КАКОЙ/*_____ -->*К ВОПРОСУ 61-62*
(05) В районной, городской больнице -->*К ВОПРОСУ 63-64*
(06) В областной, краевой больнице -->*К ВОПРОСУ 63-64*
(07) В ведомственной больнице -->*К ВОПРОСУ 63-64*
(08) В специализированной больнице, клинике -->*К ВОПРОСУ 63-64*
(09) В диспансере -->*К ВОПРОСУ 63-64*
(98) В больнице другого типа */КАКОЙ/* _____ -->*К ВОПРОСУ 63-64*
(99) Затрудняюсь ответить -->*К ВОПРОСУ 65*

ЕСЛИ РАБОТАЕТ В ПОЛИКЛИНИКЕ, ТО СПРОСИТЕ:

61. Ваша поликлиника относится к какой-либо организации, предприятию, учреждению?

(1) Да
(2) Нет
(9) Затрудняюсь ответить

---

62. Сколько врачей работает в Вашей поликлинике?

!_____! */ЗАПИШИТЕ КОЛИЧЕСТВО ВРАЧЕЙ/*
(999) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

ПЕРЕХОДИТЕ К ВОПРОСУ 150

ЕСЛИ РАБОТАЕТ В БОЛЬНИЦЕ, ТО СПРОСИТЕ:

63. Есть ли в Вашей больнице служба скорой помощи?

(1) Да
(2) Нет
(9) Затрудняюсь ответить

---

64. На сколько больничных коек расчитана Ваша больница?

!_____! */ЗАПИШИТЕ КОЛИЧЕСТВО КОЕК/*
(999) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

СПРОСИТЕ ВСЕХ

65. Если бы молодой человек или девушка, спросили Вас совета о том, стоит ли им выбрать профессию врача в качестве своей будущей профессии, Вы ответили бы, что стоит или дали бы совет выбрать другую профессию?

(1) Стоит выбрать профессию врача
(2) Лучше выбрать другую специальность
(9) Затрудняюсь ответить

---

66. Если бы Вам самому/самой пришлось выбирать профессию второй раз, Вы опять выбрали бы ту же специальность, по которой Вы работаете в настоящее время или выбрали бы другую профессию?

(1) Выбрал бы ту же профессию
(2) Выбрал бы другую профессию
(9) Затрудняюсь ответить

---

67. Если бы у Вас был выбор, в какой организации Вы предпочли бы работать? */ЗАЧИТАЙТЕ/*

01. В государственной
02. В акционерной, где Вы обладали бы частью акций
03. В частной, где владельцем были бы Вы сами
04. В частной, где владельцем был бы другой человек
05. В общественной организации, благотворительном обществе
06. В совместном предприятии
07. Хотел бы работать за границей
08. Заниматься частной практикой
(09) Совсем не хотел бы работать
(99) Затрудняюсь ответить

---

150. ПОЛ РЕСПОНДЕНТА

(1) Мужской
(2) Женский

151. Сколько лет Вам исполнилось в последний день рождения?

!_____! (напишите)

152. Скажите, пожалуйста, какое учебное заведение Вы закончили? */НЕ ЧИТАТЬ/*

(1) Медицинский техникум, курсы мед.сестер
(2) Фармацевтический техникум
(3) Высшее медицинское учебное заведение
(4) Кандидат медицинских наук
(5) Доктор медицинских наук

153. Скажите, пожалуйста, каков Ваш средний ежемесячный доход за последние два или три месяца, после вычета всех налогов? */ЗАЧИТАЙТЕ ИНТЕРВАЛЫ ДОХОДА ДО ТЕХ ПОР, ПОКА НЕ ПОЛУЧИТЕ "Да"/*

01. Менее 20 тыс. рублей
02. От 20 до 30 тыс.рублей
03. От 30 до 40 тыс.рублей
04. От 40 до 50 тыс. рублей
05. От 50 до 70 тыс.рублей
06. От 70 до 100 тыс.рублей
07. От 100 до 200 тыс.рублей
08. От 200 до 300 тыс.рублей
09. От 300 до 400 тыс.рублей
10. От 400 до 600 тыс.рублей
11. От 600 до 1 млн. рублей
12. Более 1 млн.рублей
(97) Отказ от ответа */НЕ ЧИТАТЬ/*
(99) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

---

154. Скажите, пожалуйста, какой Ваш средний ежегодный доход, который Вы получаете дополнительно к своей зарплате от частных пациентов, пациентов, приехавших из других городов, за срочное оказание услуг и т.д.? */ЗАЧИТАЙТЕ ИНТЕРВАЛЫ ДОХОДА ДО ТЕХ ПОР, ПОКА НЕ ПОЛУЧИТЕ "Да"/*

01. Менее 10 000 рублей
02. От 10 до 50 тыс.рублей
03. От 50 до 100 тыс.рублей
04. От 100 до 250 тыс. рублей
05. От 250 до 500 тыс.рублей
06. От 500 до 1 млн.рублей
07. Более 1 млн.рублей
(96) Ничего не получаю дополнительно
(97) Отказ от ответа */НЕ ЧИТАТЬ/*
(99) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

---

155. Скажите, пожалуйста, какова Ваша специальность в настоящее время?

(1) Врач-терапевт -->*К ВОПРОСУ 157*
(2) Врач-стоматолог -->*К ВОПРОСУ 157*
(3) Врач-специалист в другой области -->*К ВОПРОСУ 157*
(4) Директор или зам.директора, администратор больницы, поликлиники, аптеки -->*К ВОПРОСУ 156*
(5) Мед.сестра -->*К ВОПРОСУ 157*
(6) Фельдшер -->*К ВОПРОСУ 157*
(7) Фармацевт -->*К ВОПРОСУ 156*
(8) Другое */КТО ИМЕННО/*_____ -->*К ВОПРОСУ 157*

ЕСЛИ ФАРМАЦЕВТ СПРОСИТЕ:

156. Скажите, пожалуйста, Вы работаете в частной организации, государственной организации, в совместном предприятии или в организации, которая находится в стадии перехода от государственной в частную? */НЕ ЧИТАТЬ/*

(1) В частной организации
(2) В государственной организации
(3) На совместном предприятии
(4) В стадии перехода от государственной в частную
(8) Другое */КТО ИМЕННО/*_____

---

157. Скажите пожалуйста, какова Ваша должность в настоящее время?

(1) Рядовой врач
(2) Заведующей отделением
(3) Глав.врач или зам.глав.врача, директор или зам.директора, администратор больницы, поликлиники, аптеки
(4) Рядовая мед.сестра
(5) Старшая мед.сестра
(6) Фельдшер
(7) Фармацевт
(8) Другое */КТО ИМЕННО/*_____

---

158. Сколько человек работает в Вашем медицинском учреждении?

!_____! */ЗАПИШИТЕ КОЛИЧЕСТВО ЧЕЛОВЕК/*
(999) Затрудняюсь ответить */НЕ ЧИТАТЬ/*

ЗАЧИТАЙТЕ РЕСПОНДЕНТУ: Это все вопросы, которые мы хотели Вам задать. Если у Вас, в свою очередь, есть вопросы ко мне, я постараюсь на них ответить. Вы можете позвонить нам и позже. Напоминаю наш телефон в Москве: 128-56-01. Благодарим за помощь в работе!

ИНТЕРВЬЮЕР: НАПИШИТЕ ЧЕТКО ВАШУ ФАМИЛИЮ, ИМЯ, ОТЧЕСТВО

_____

Ручательство интервьюера: Я удостоверяю, что опрос проведен мною в соответствии с Инструкцией методом личного интервью с отобранным по Инструкции респондентом.

Номер интервьюера !_____! Подпись _____

Дата проведения интервью: _____ число май месяц 1994 года

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496

Healthy Russia 2000

Presentation to U.S. AID and the Russian Federation

July 1994

147

HEALTH CARE RESEARCH IN RUSSIA

May 1 - June 15, 1994

- **FOCUS GROUPS - 10 Groups in 4 Cities**
- **MEDIA SURVEY - 59 Cities (IPCC)**
- **CONSUMER SURVEY - 44 Cities/Villages**
  Over 1500 Adults Interviewed
- **PROVIDER SURVEY - 39 Cities/Villages**
  Over 275 Health Care Providers Interviewed
- **INTERVIEWS (Employers/Insurance Companies)**
  20 Cities/138 Interviews

HEALTH CARE CONSUMER SURVEY

INTERVIEW SITES

Central & North Russia

Moscow
Ozery
Ryazan
St. Petersburg
Luga
Chichulino
Plashkino
Stremutk
Podosie
Ershovo
Priozerie
Kormy
Toroshino
Chernihovizy
Bolshiezhezly
Ezhva
Zelenez
Vilgort
Krasnogorsk
Vologda

Southern Russia

Kursk
Samara
Syzran
Laischevo
Stolbchy
Narmonka
Sokury
Vasurinskaya
Yuzny
Elabuga
Izobilnyi
Novotroizkiy
Tischenskoe
Krasnyiyar

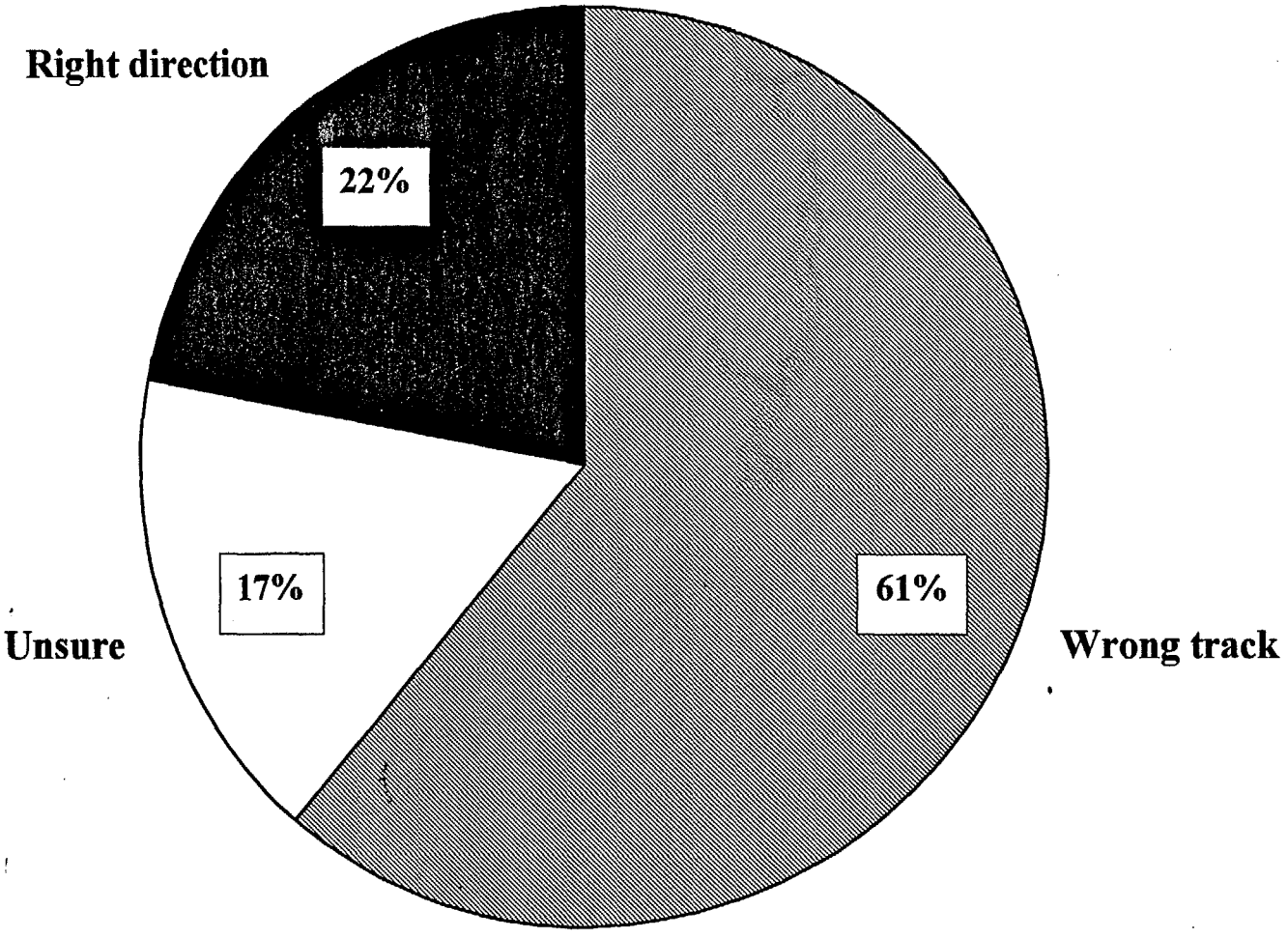
Ural/Siberia

Oktyabrskoe
Salavat
Perm
Kungur
Nevjansk
Novosibirsk
Zavialov
Oktiabrskiy

Far East

Nazarov
Khabarovsk

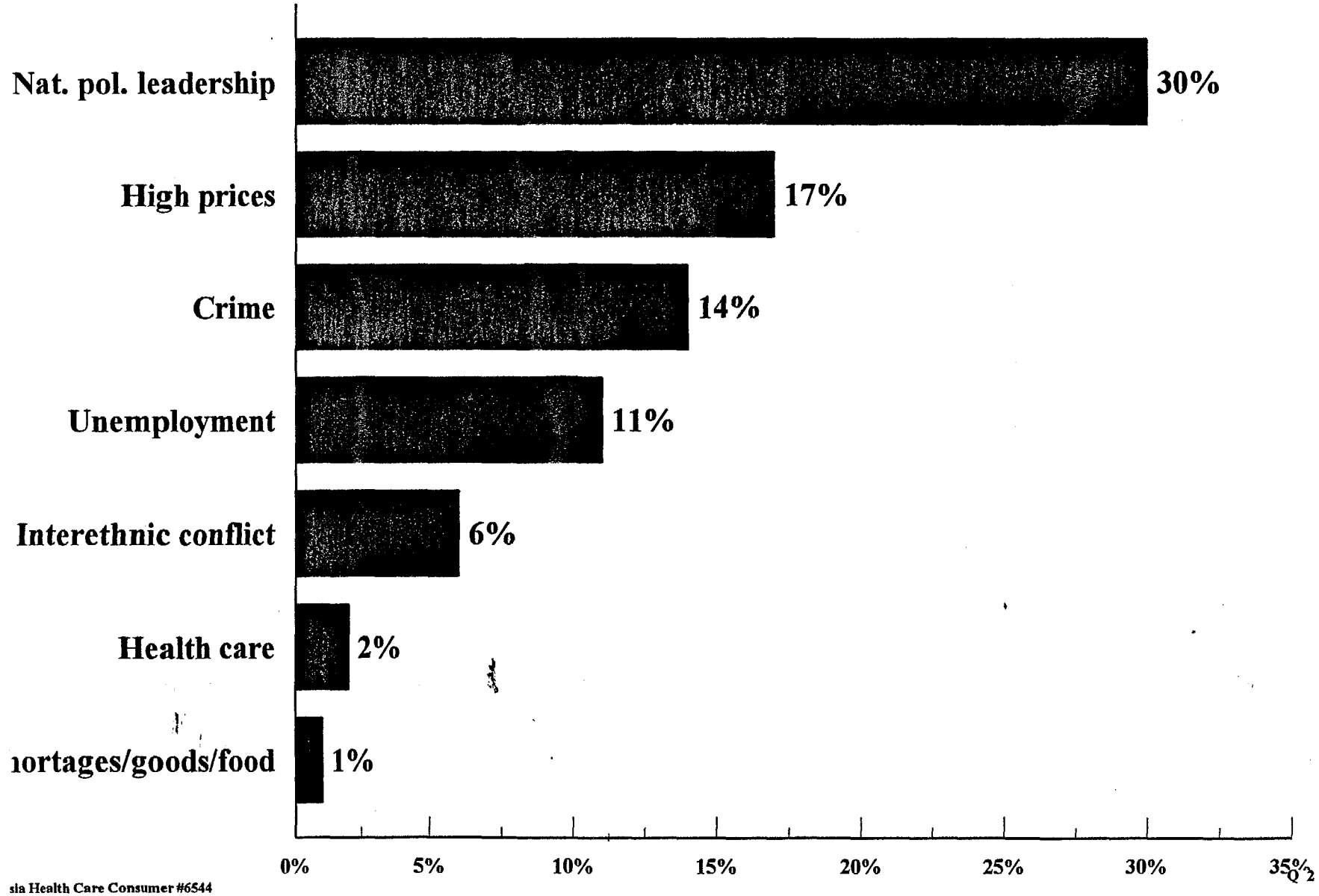
Direction Things in Russia are Going



Health Care Consumer #6544

Q 1

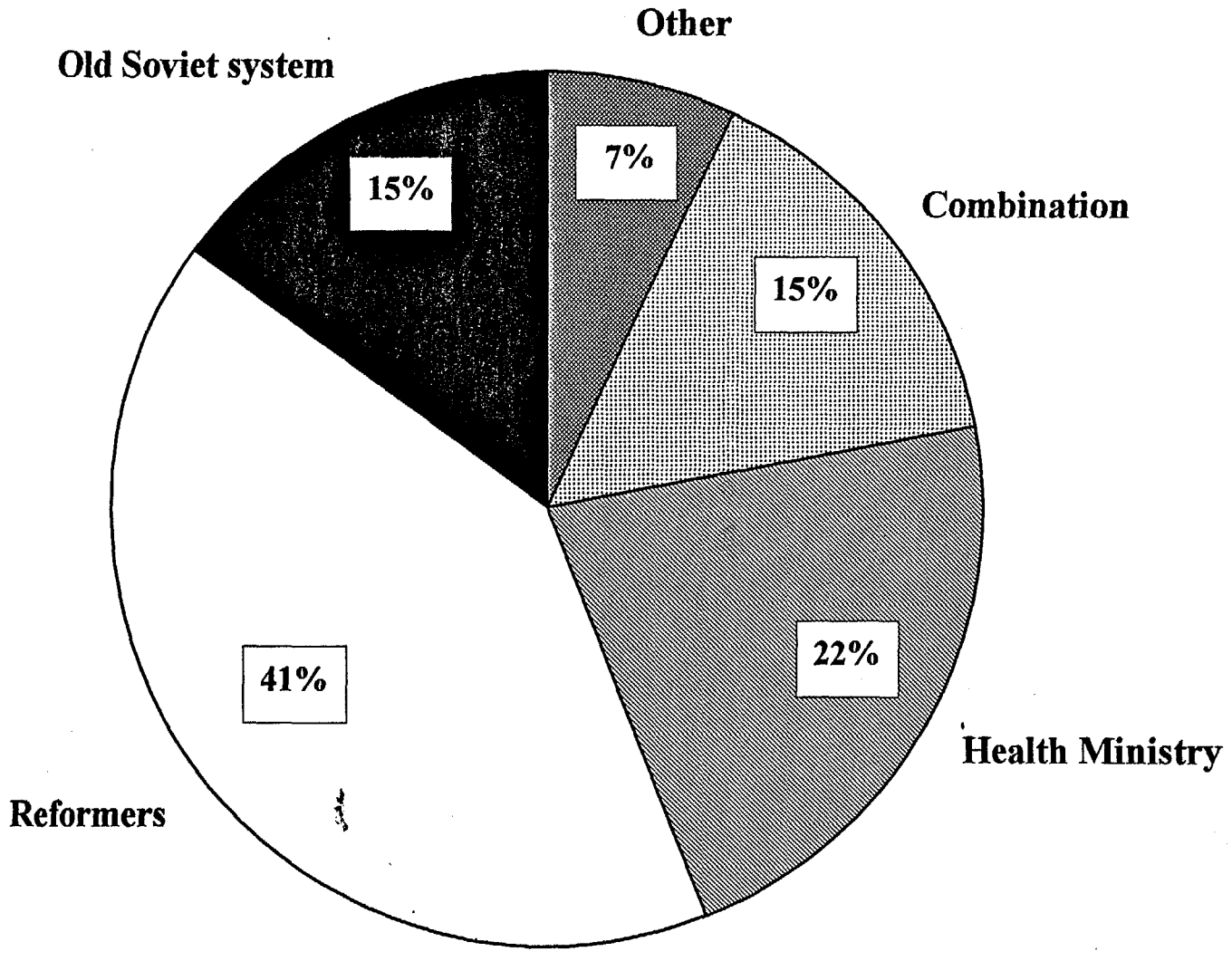
Most Important Problem in Russia



sia Health Care Consumer #6544

Who do you Blame for Russia's Health Care Problems?

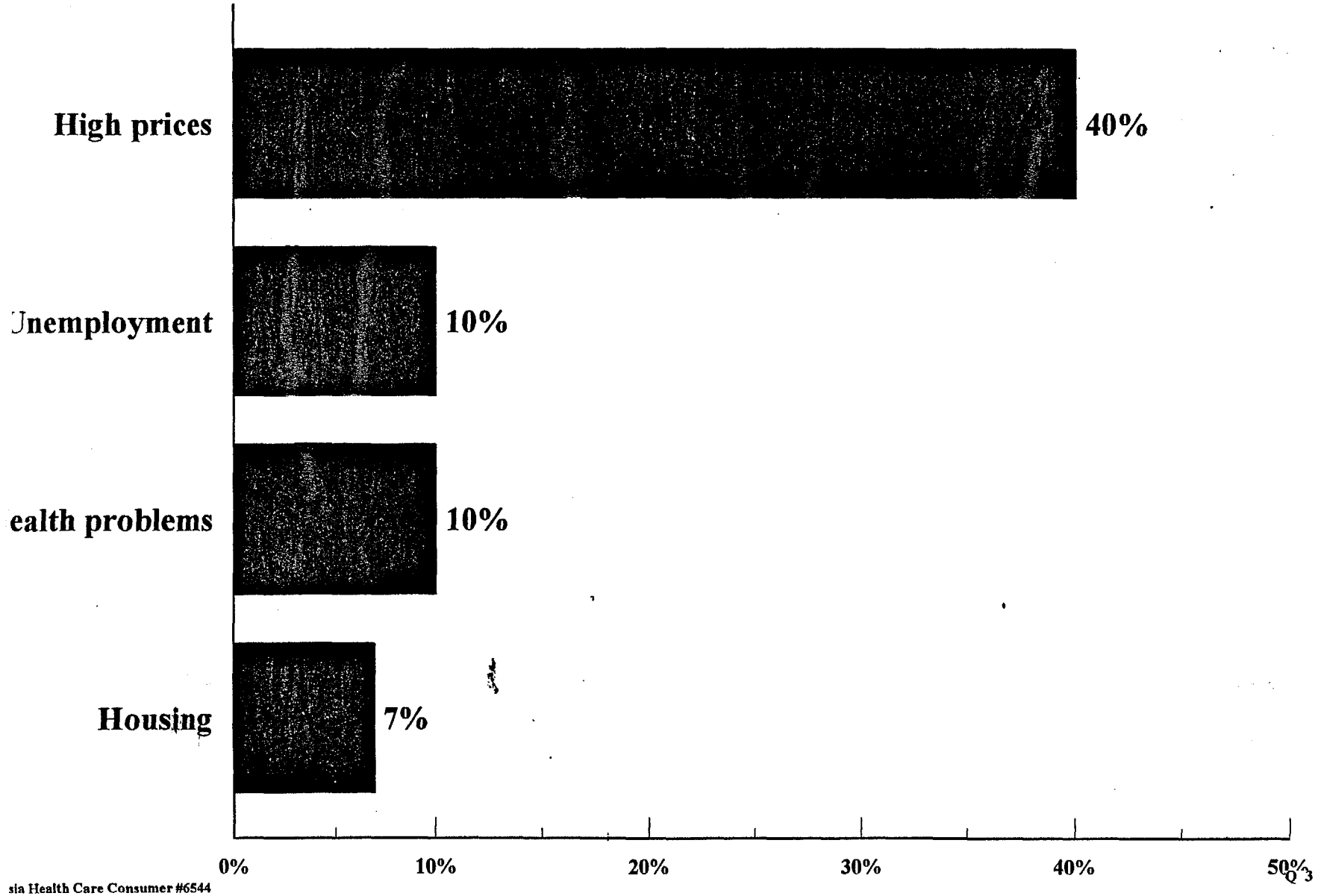
(Among not satisfied with health care responses)



sia Health Care Provider #6559

Q 2

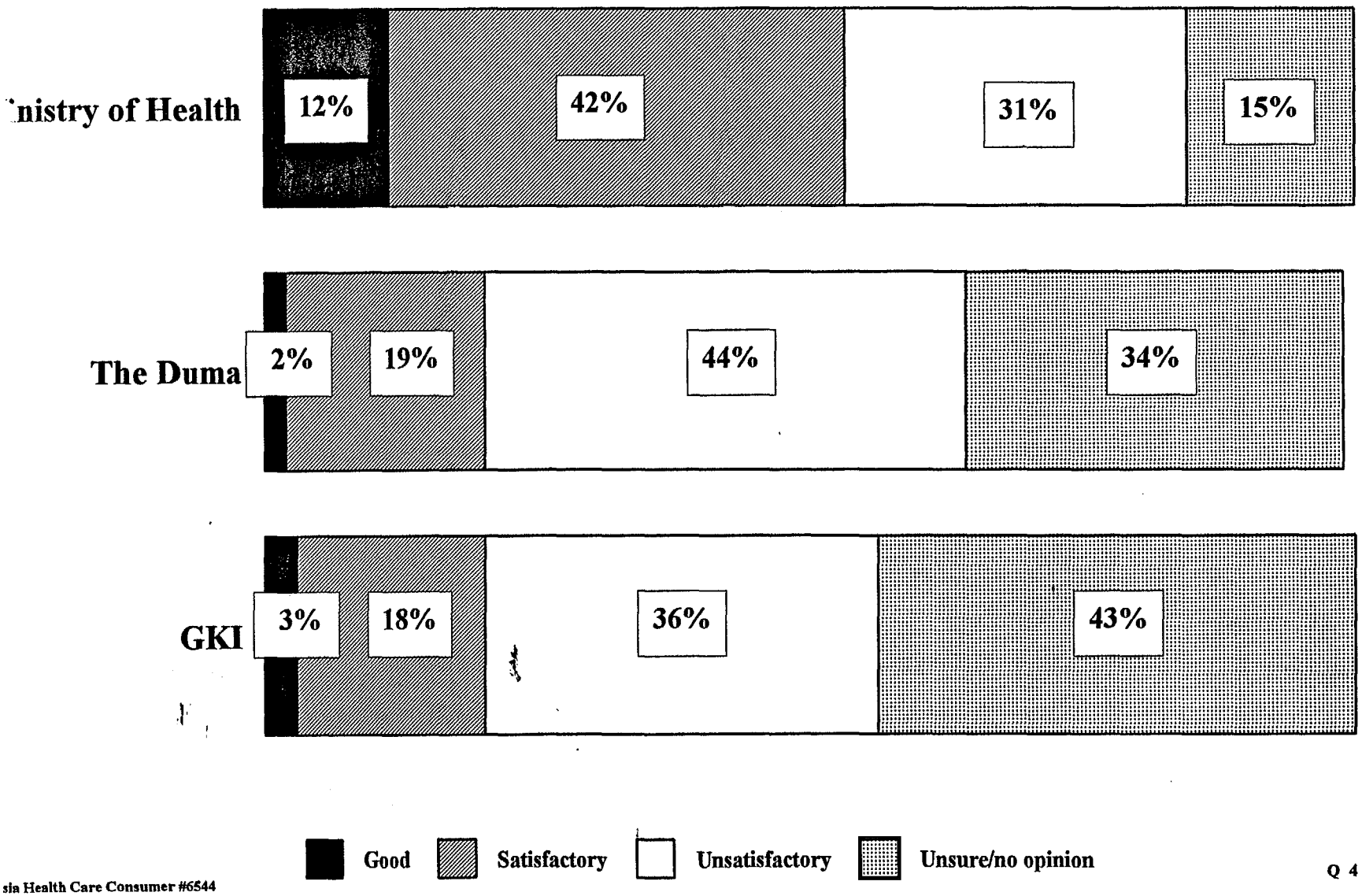
Number One Problem Facing You Personally



sia Health Care Consumer #6544

Q 3

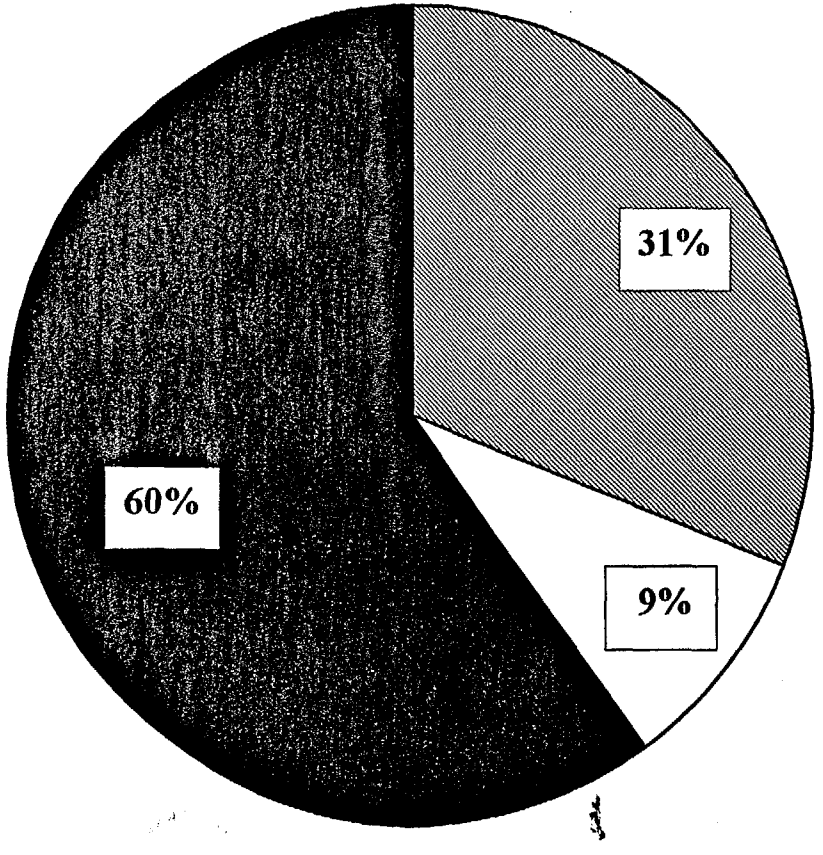
Rate the Job of...



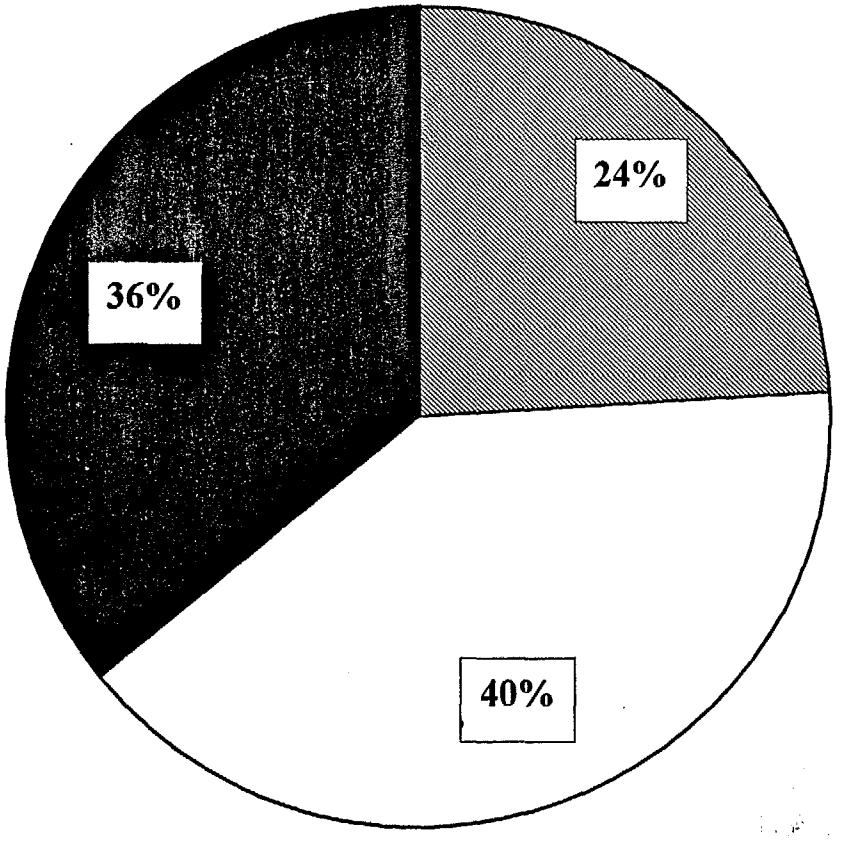
Q 4-6

sia Health Care Consumer #6544

Satisfaction with...



Local Polyclinic



Oblast Health Committee

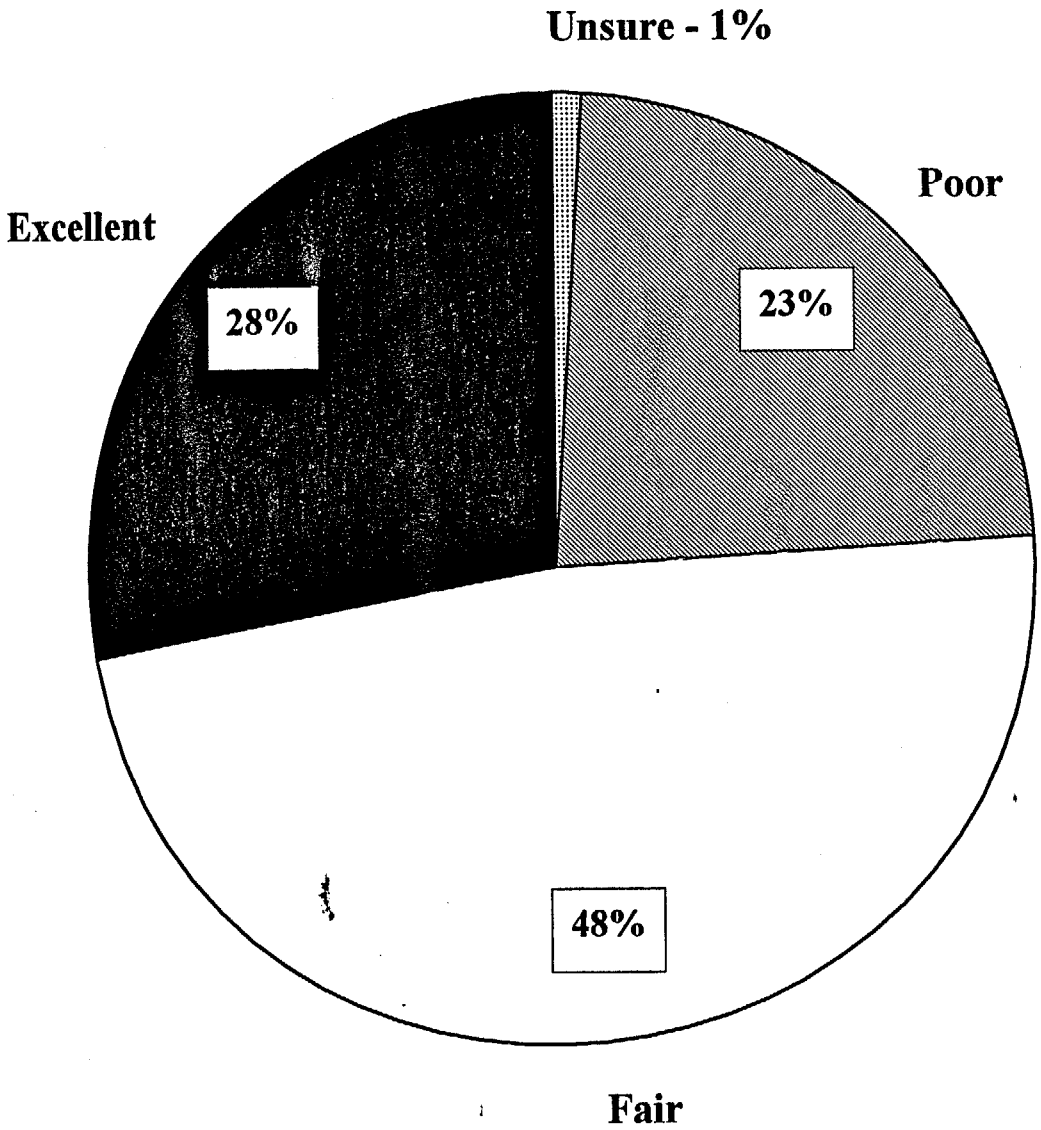
Satisfied Unsure Dissatisfied

Q 7, Q 8

ia Health Care Consumer #6544

505

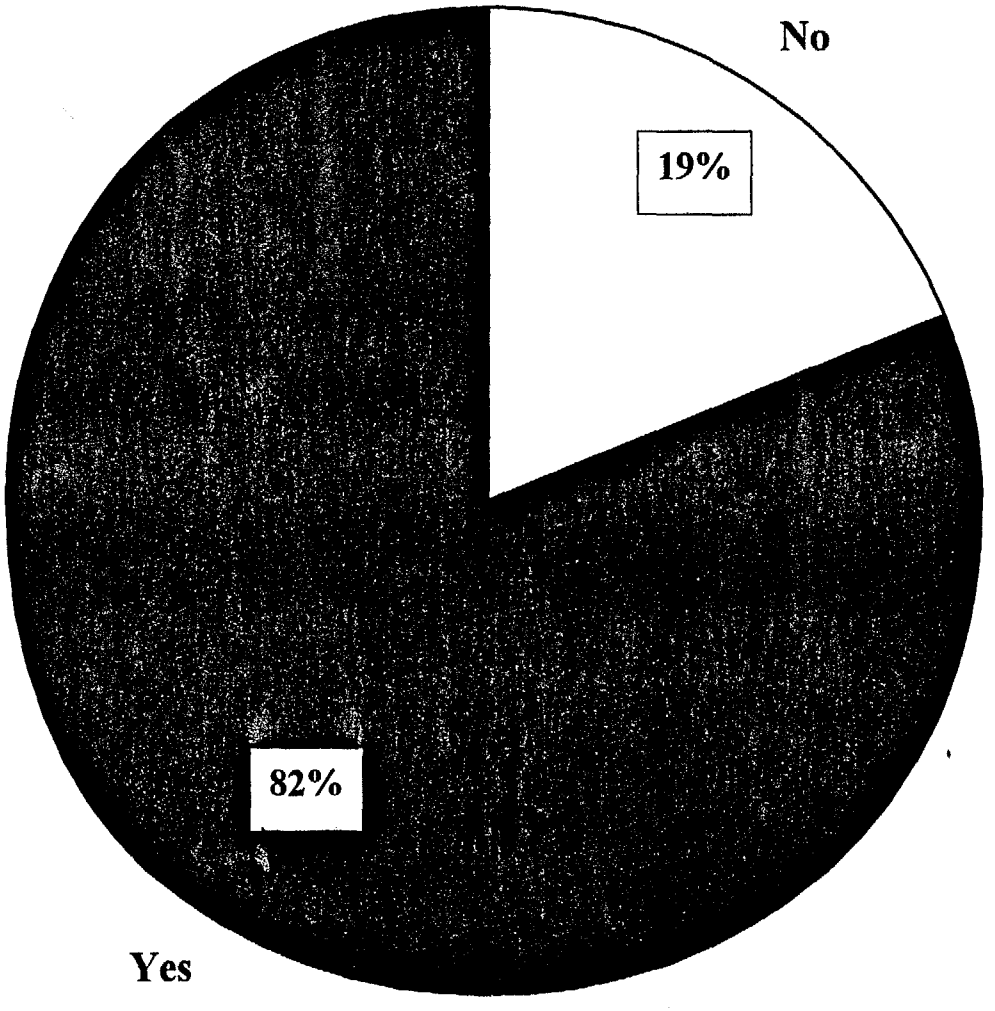
Rate Your Personal Health



Q 9

586

ou or Family Member used Unpaid Medical Care in Last 2 Years



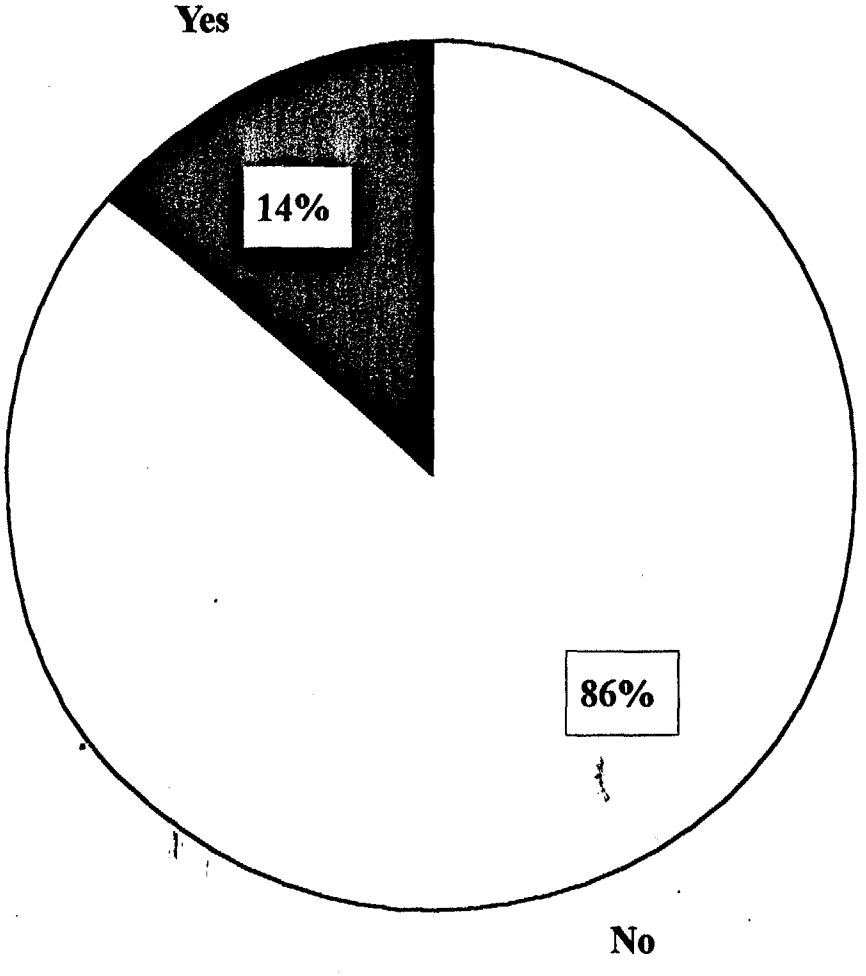
ia Health Care Consumer #6544

Q 10

507

Did You Have to Give Gifts to Pay for Services?

(Among those who used unpaid care)

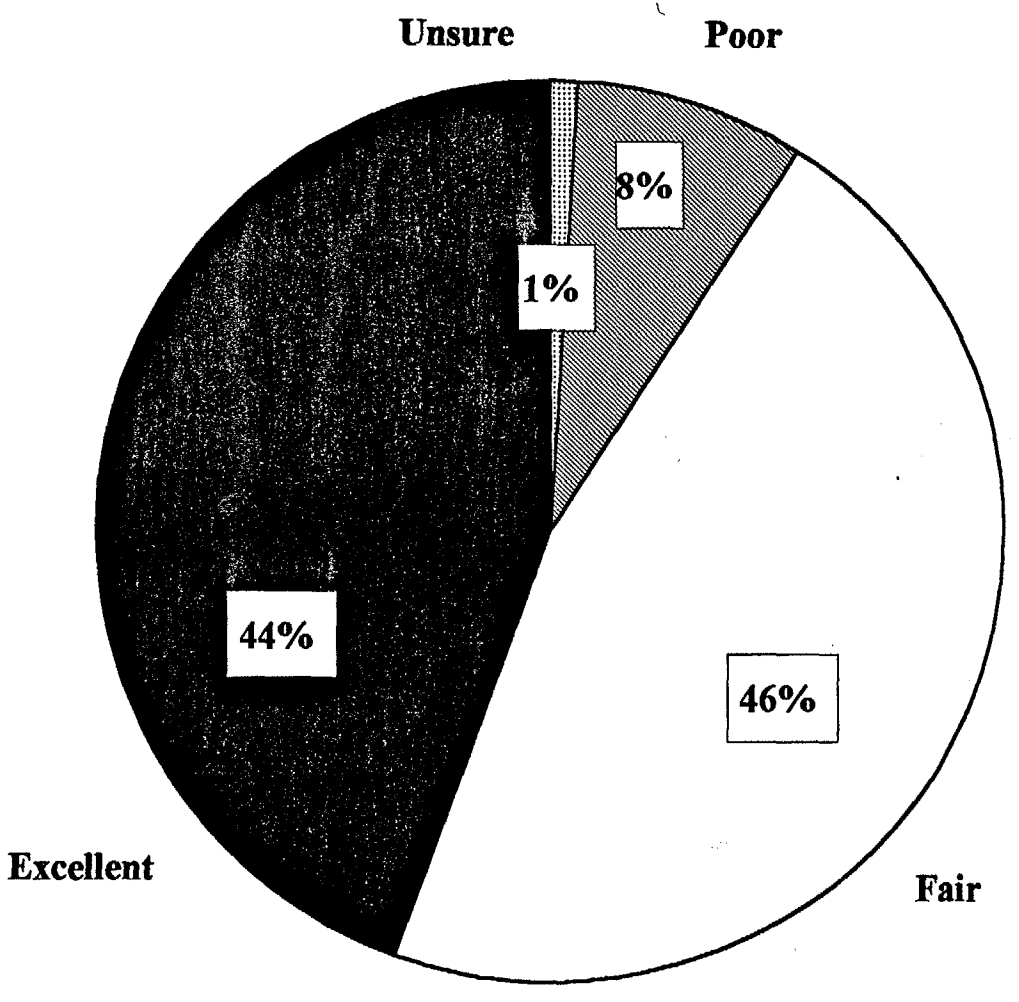


Russia Health Care Consumer #6544

Q 13

Rate Medical Care Received

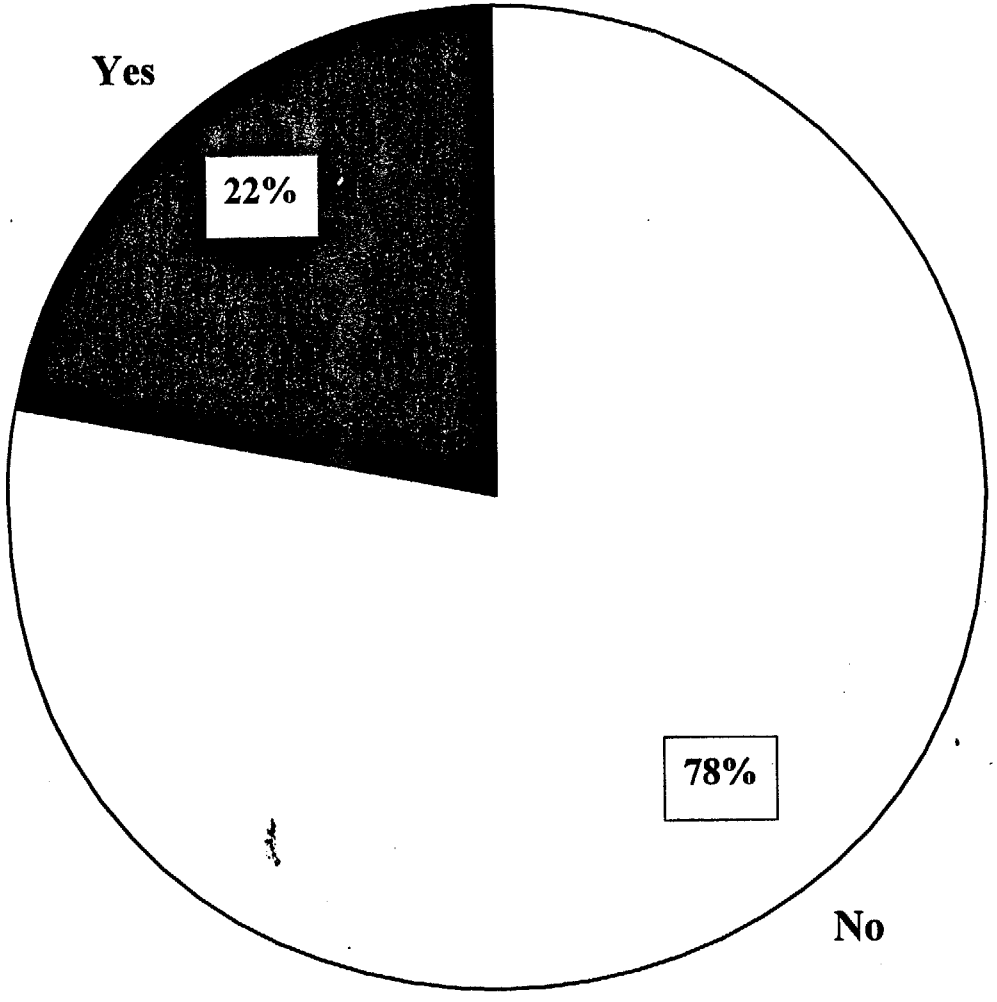
(Among those who used unpaid care)



Russia Health Care Consumer #6544

Q 14

ou or Family Member used Paid Medical Care in Last 2 Years

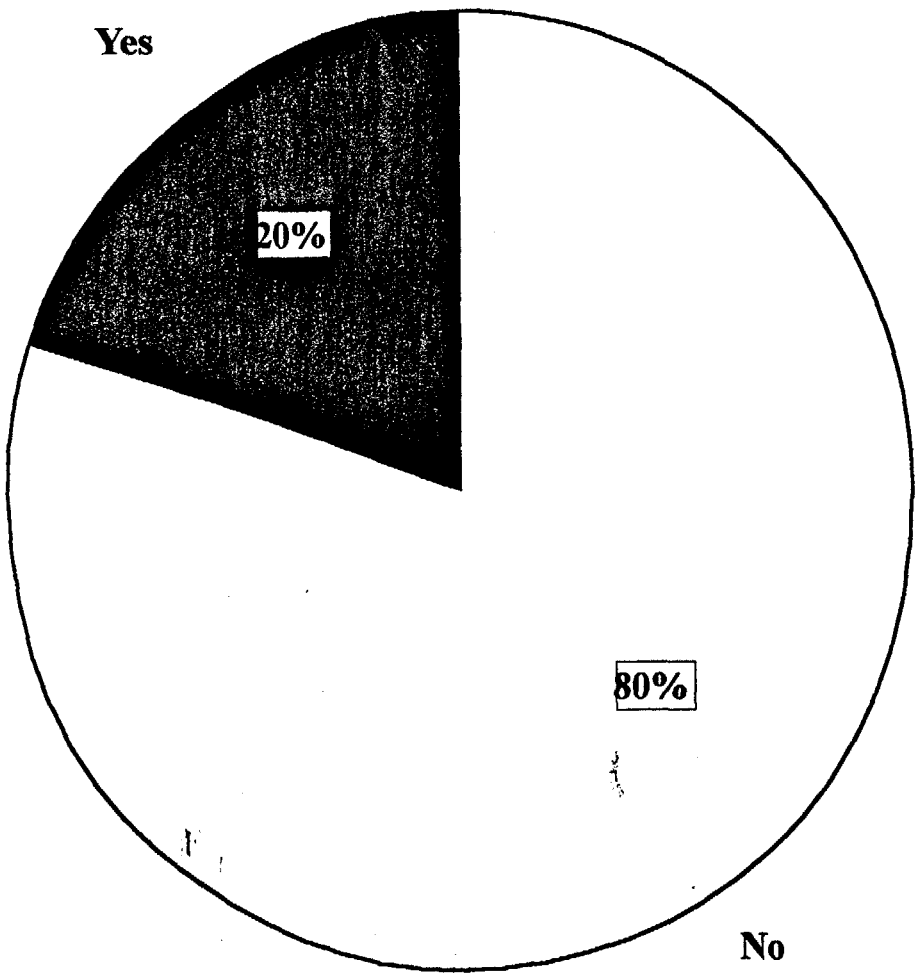


Q 16

ssia Health Care Consumer #6544

Did You Have to Give Gifts to Pay for Services?

(Among those who used paid care)

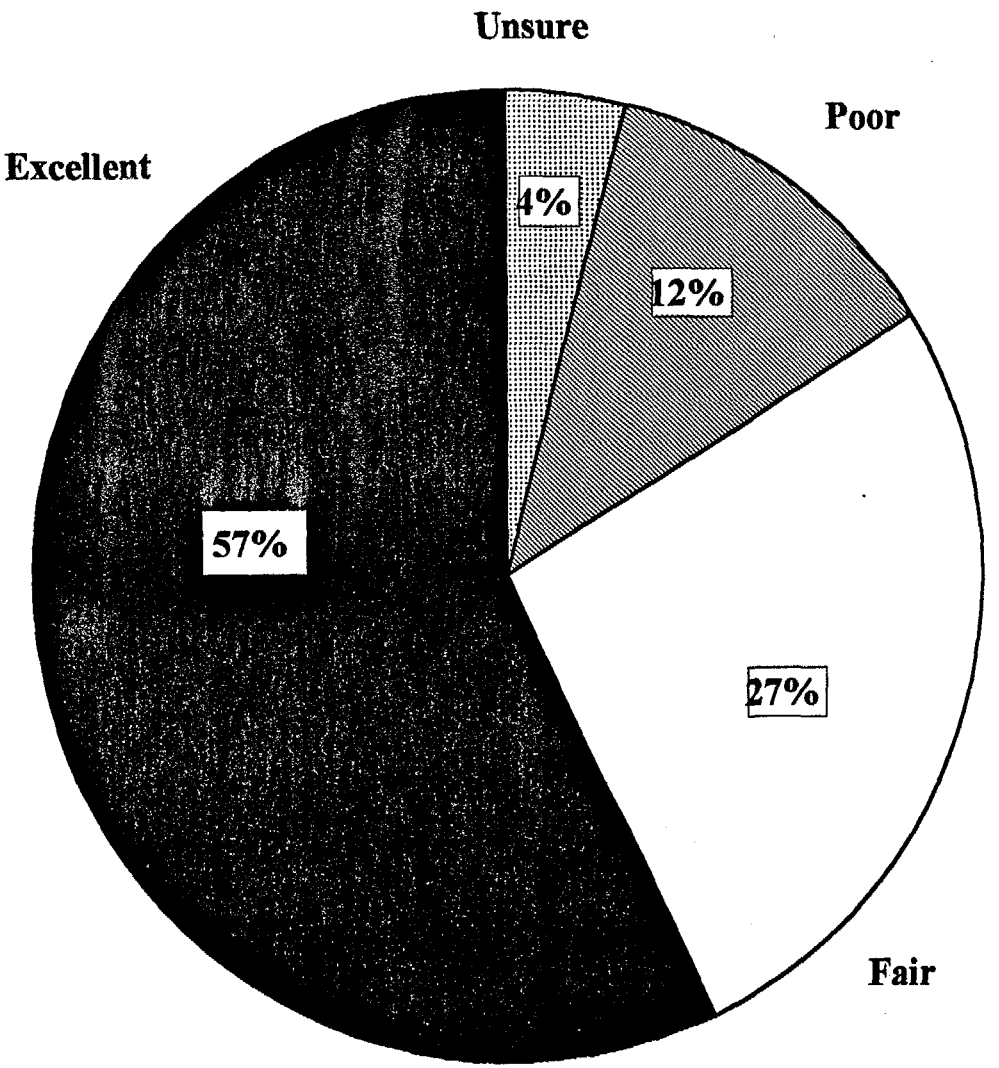


Russia Health Care Consumer #6544

Q 17A

Rate Paid Medical Care Received

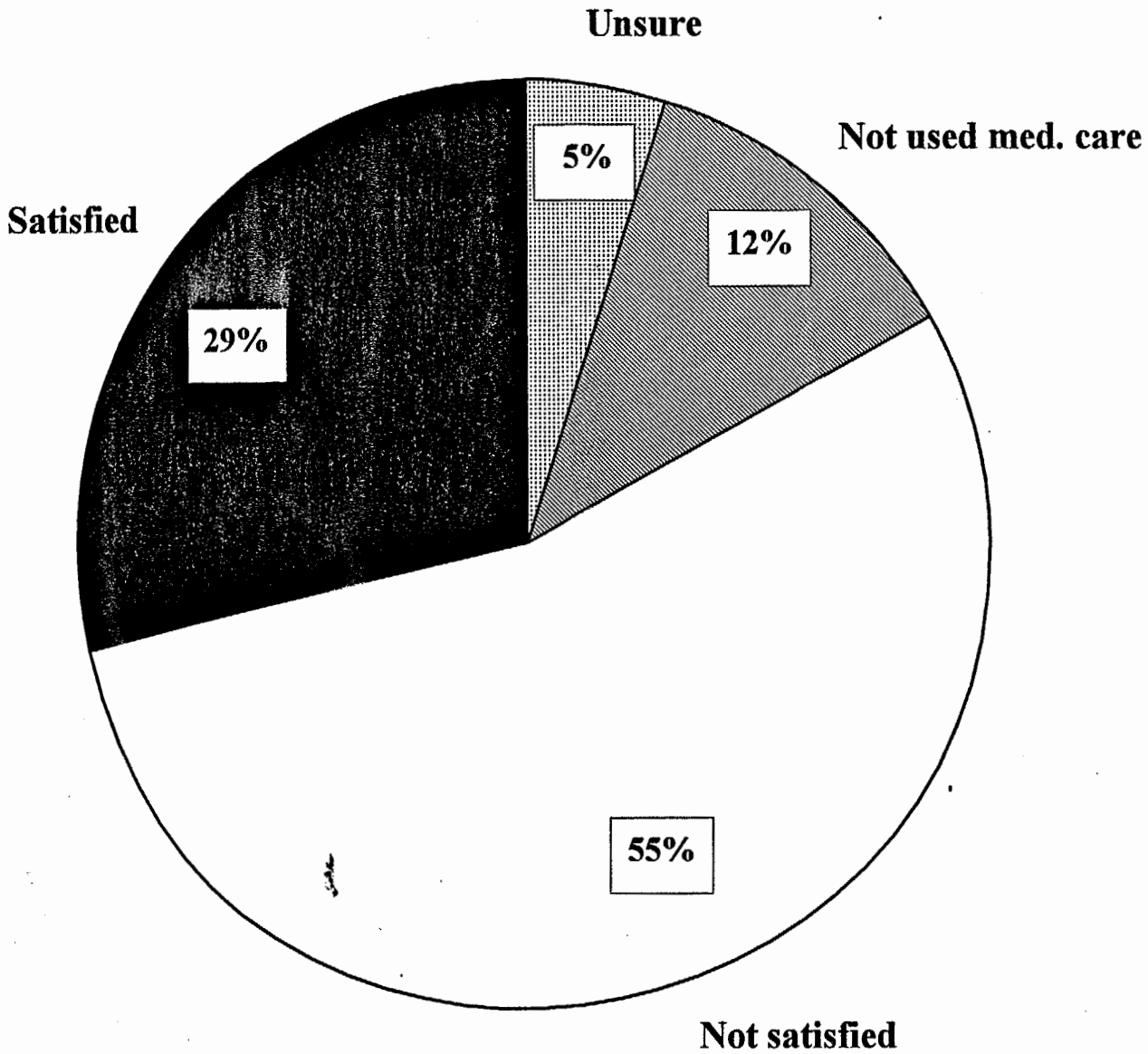
(Among those who used paid care)



Q 18

Russia Health Care Consumer #6544

Consumer: Satisfaction with Current Health Care

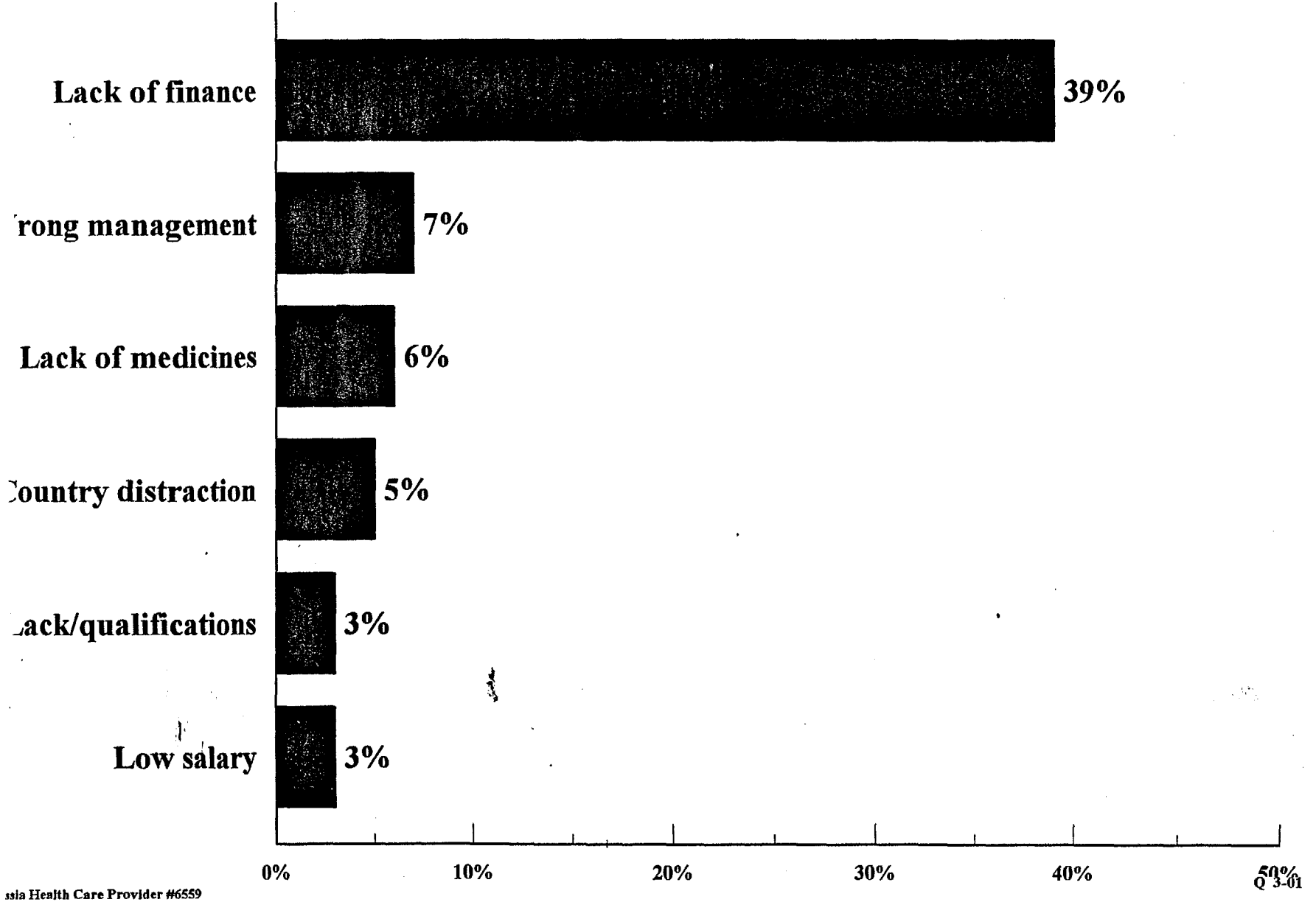


Health Care Consumer #6544

Q 19

Iain Reason you are not satisfied with Health Care System

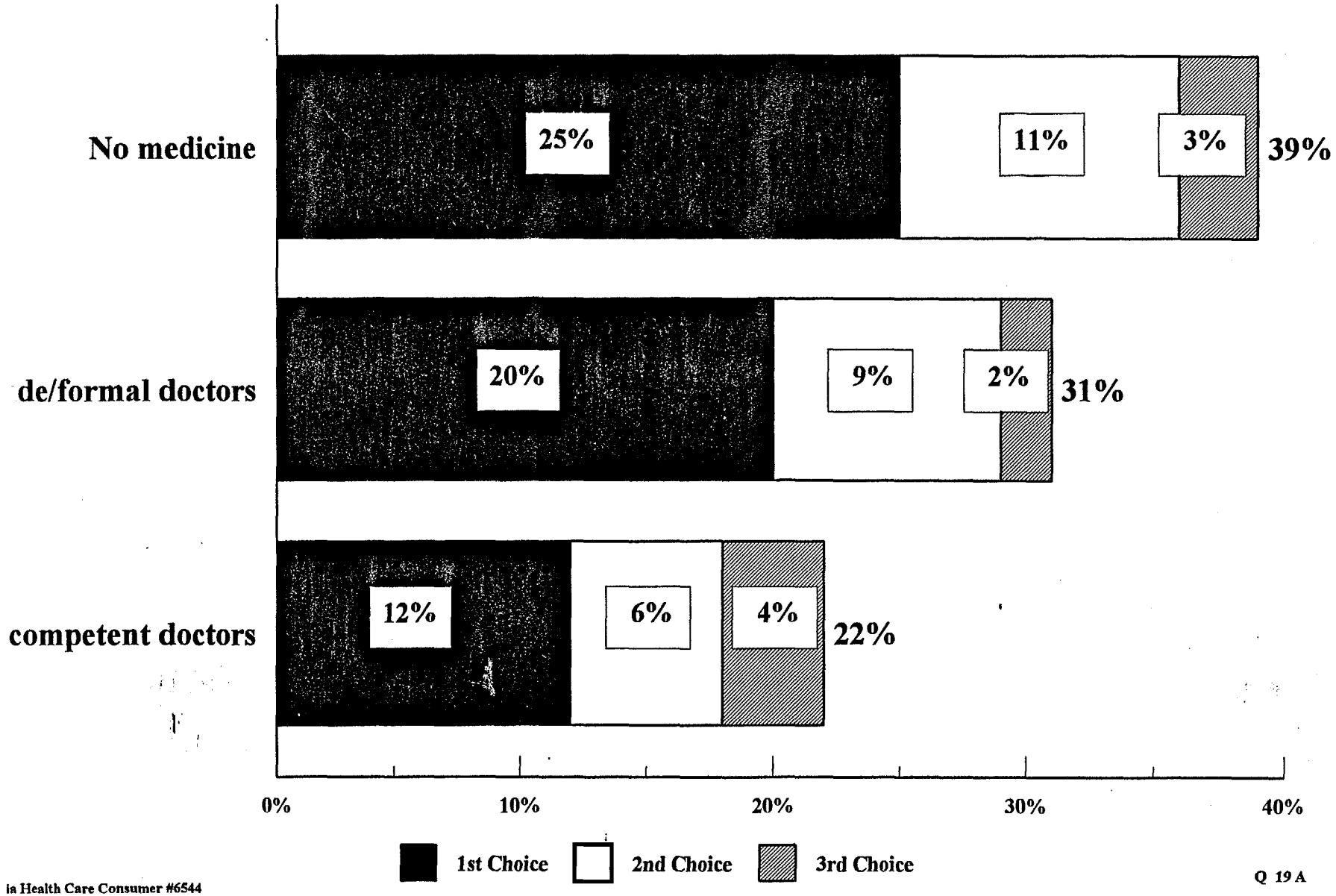
(Among not satisfied with health care responses)



ssia Health Care Provider #6559

Consumer: Most Important Reason Not Satisfied

(Among not satisfied responses)



ia Health Care Consumer #6544

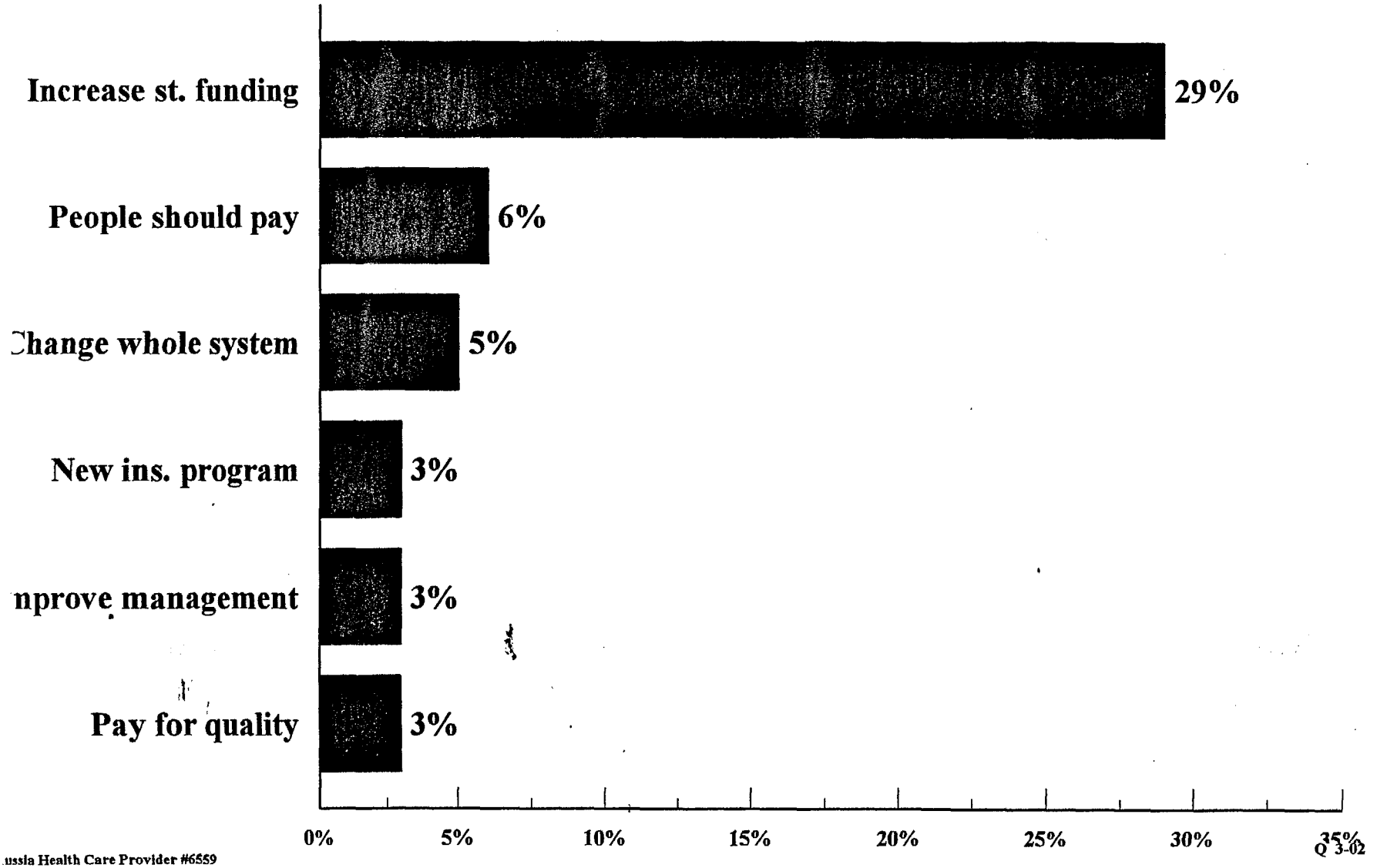
Q 19 A

5/12

Providers: How would you improve this system?

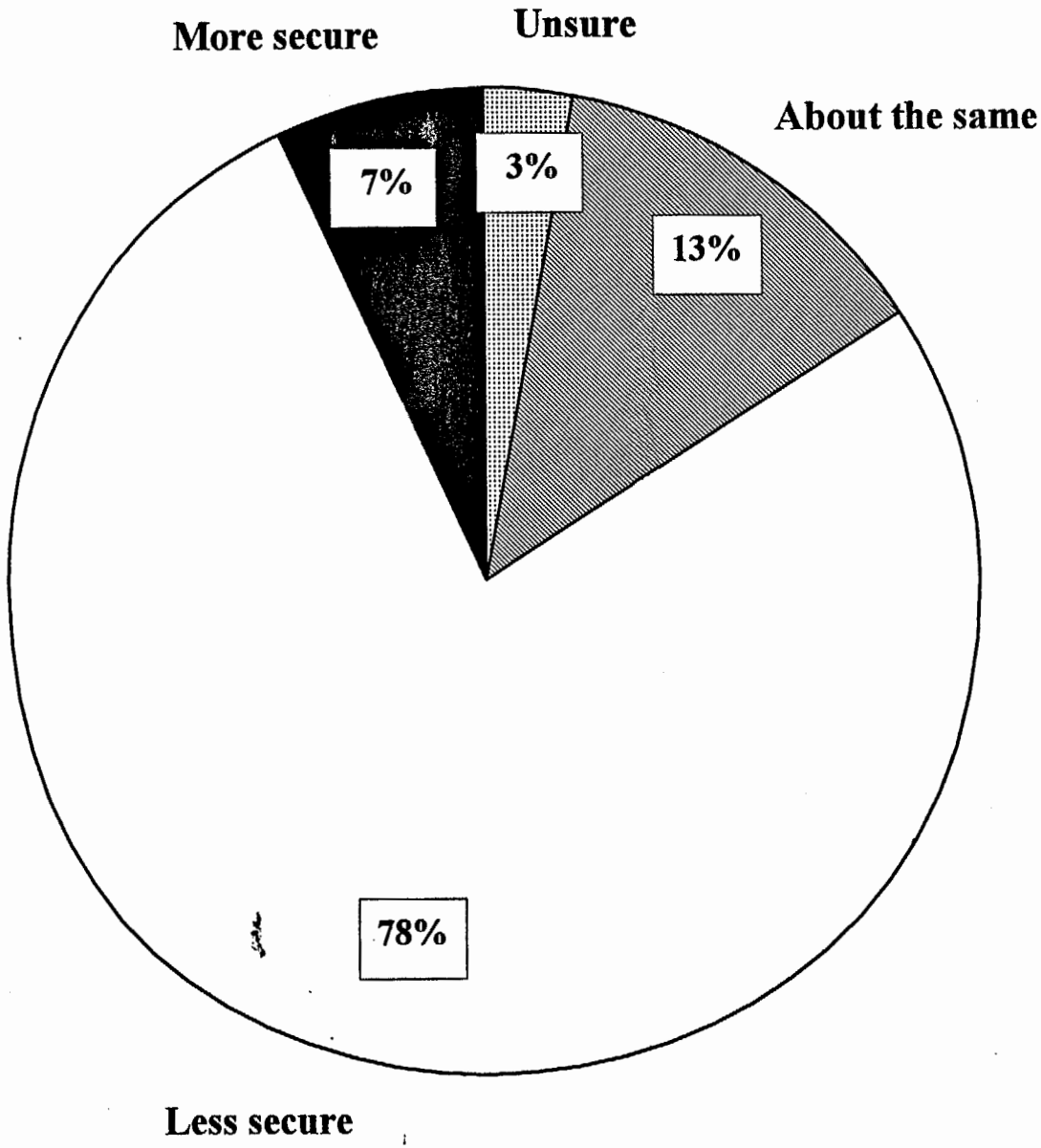
1st Mention

(Among not satisfied with health care responses)



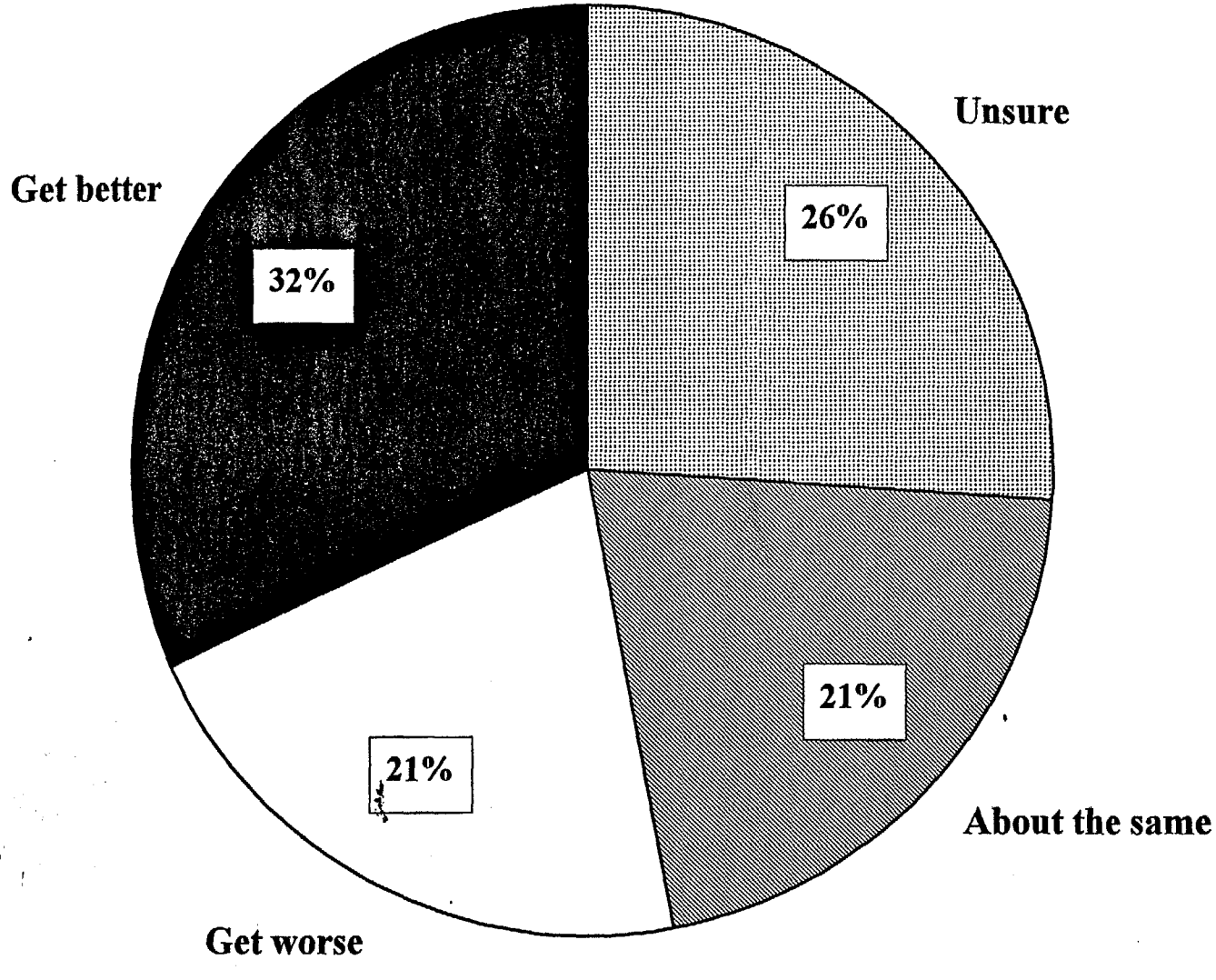
ussia Health Care Provider #6559

Providers: Health Care System Today vs. 10 Years Ago



Q 4

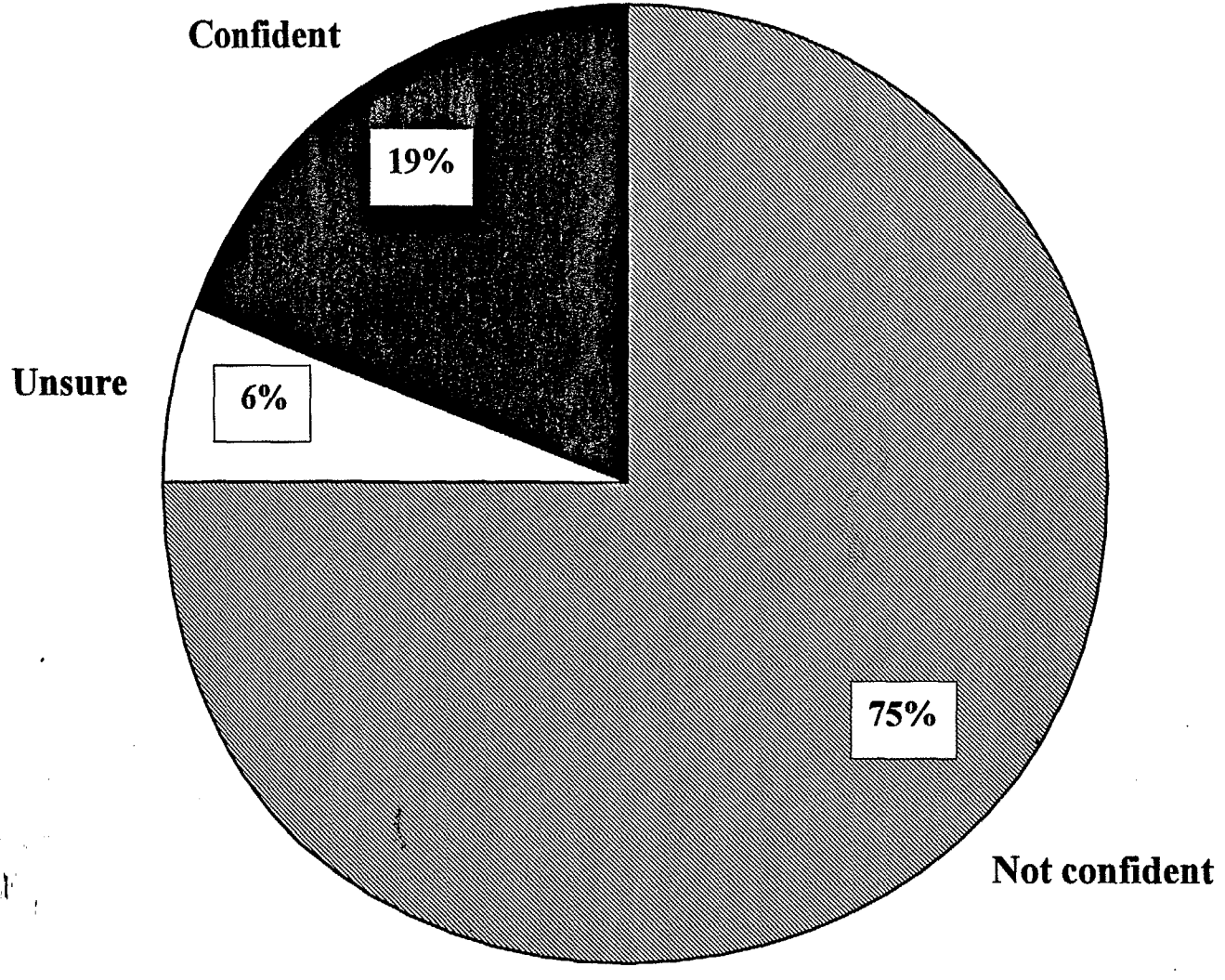
Russian Health Care in the Next 10 Years Will...



sia Health Care Consumer #6544

Q 20

Confidence that Doctor will be able to Meet Your Needs

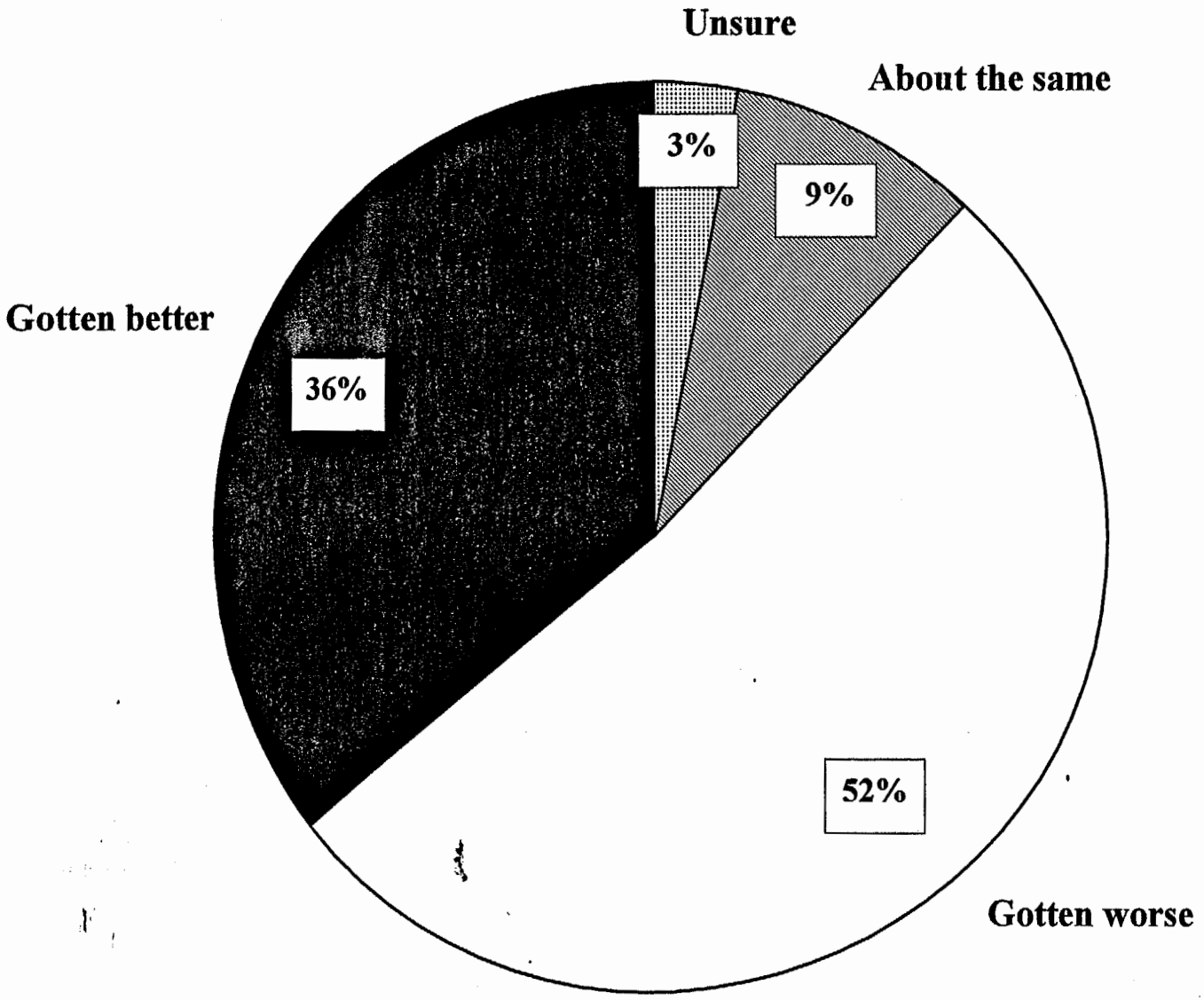


ssia Health Care Consumer #6544

Q 21

577

Availability of Medicine in Last 12 Months

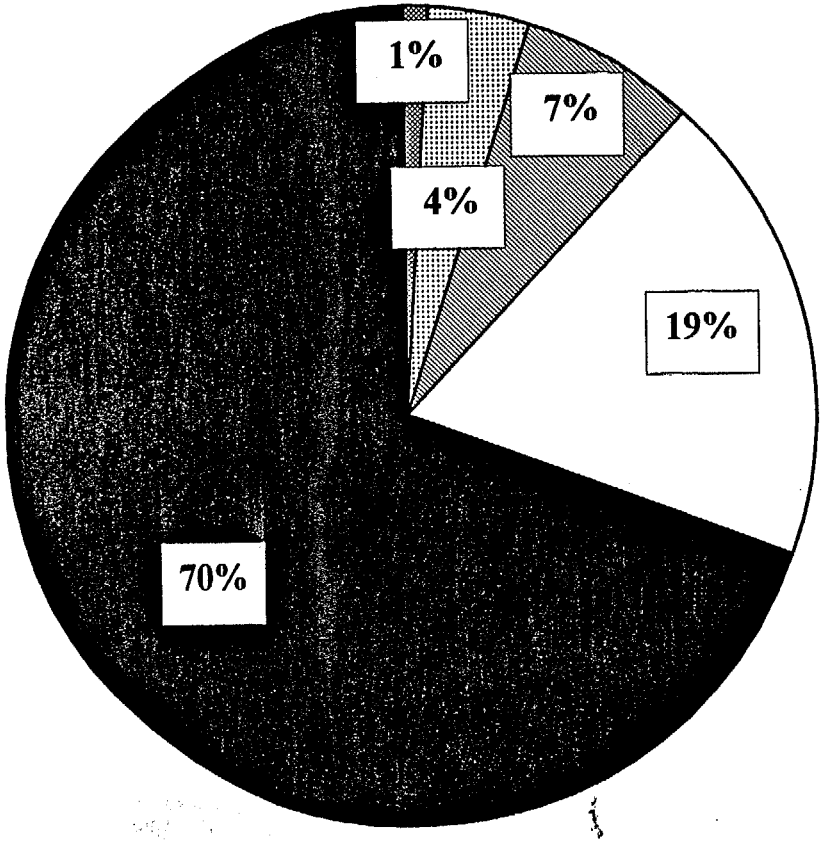


Health Care Provider #6559

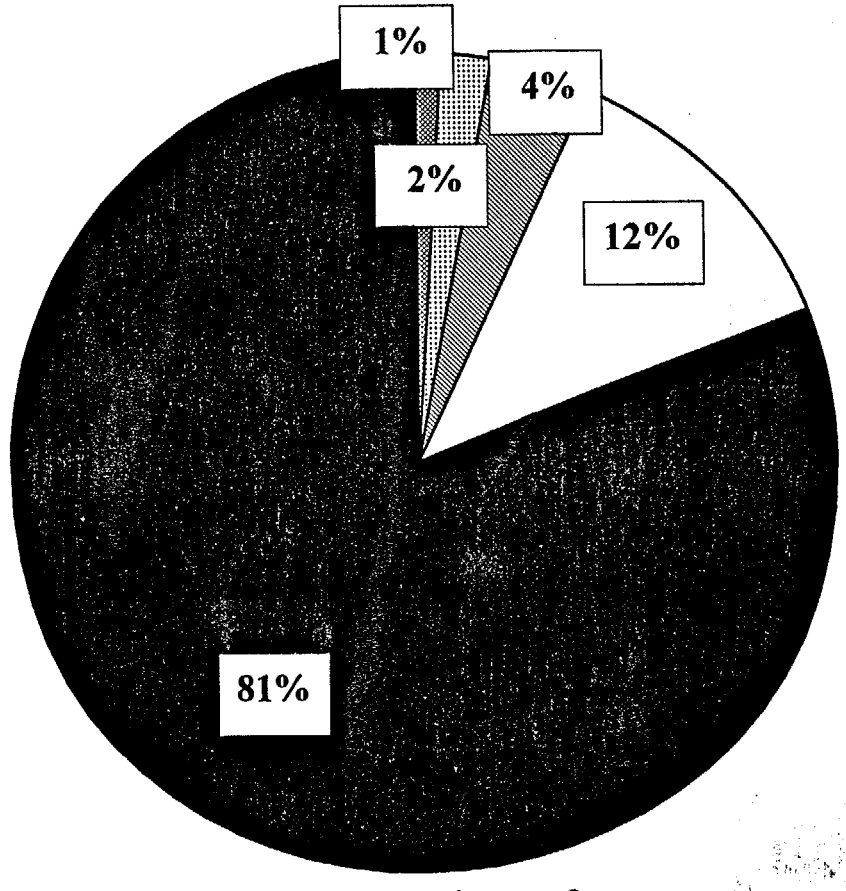
Q 7

518

Are You Personally Worried...



Might be required to pay for your family's health care



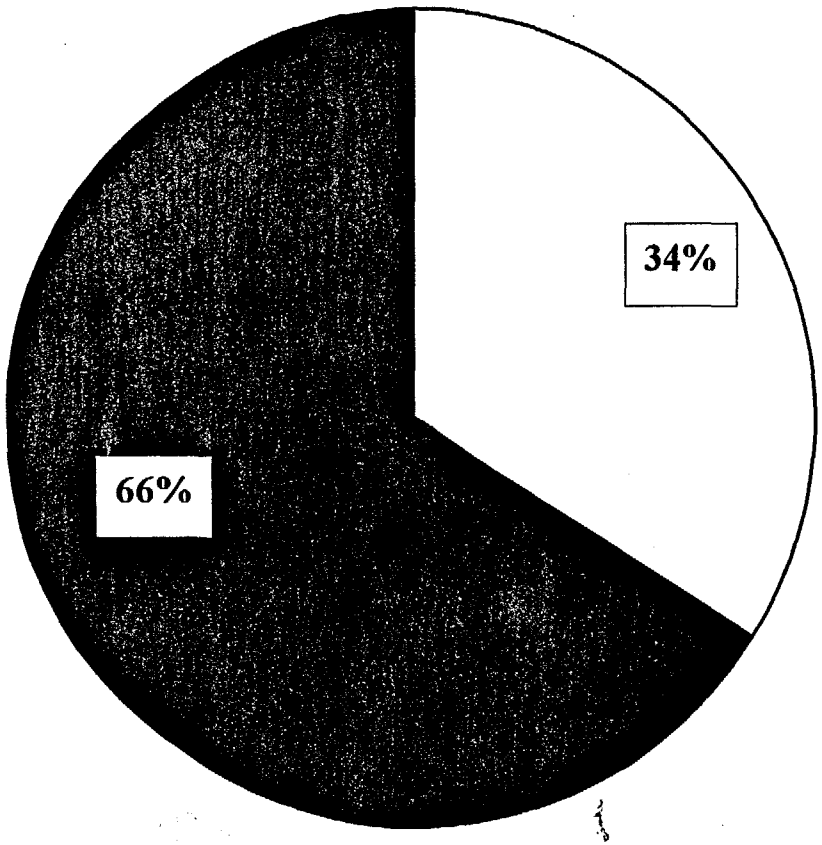
That you can't pay for catastrophic illness

A great deal | Somewhat | Not very much | Not at all | Unsure

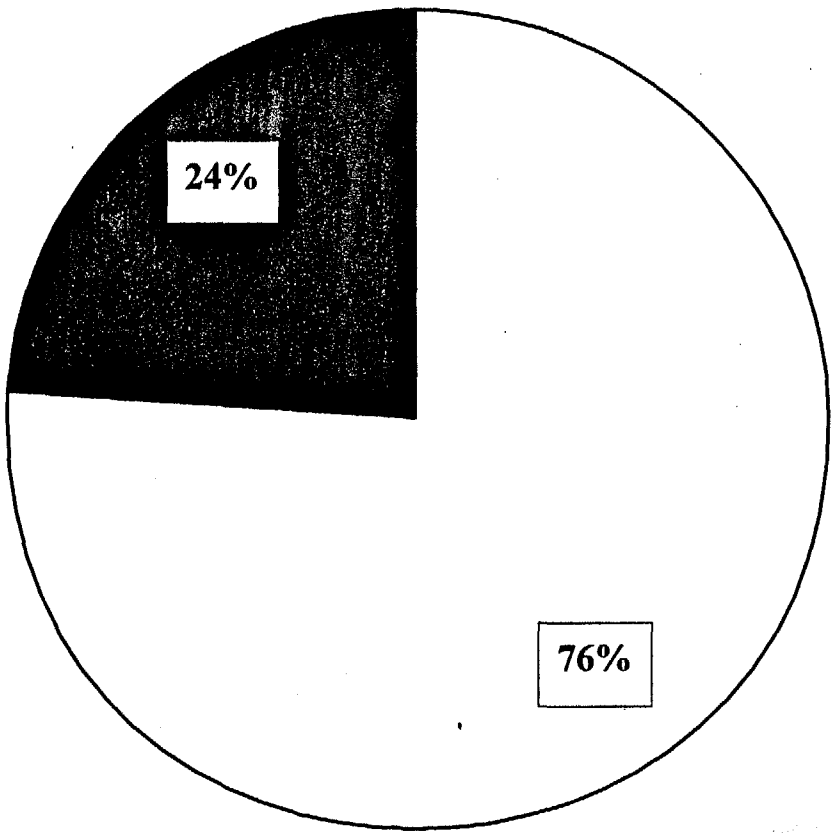
Q 25-01, Q 25-02

ussia Health Care Consumer #6544

Government Health Care Campaign



Seen, read, heard about govt. health care campaign



Will campaign change habits? (among those s/r/h of campaign)

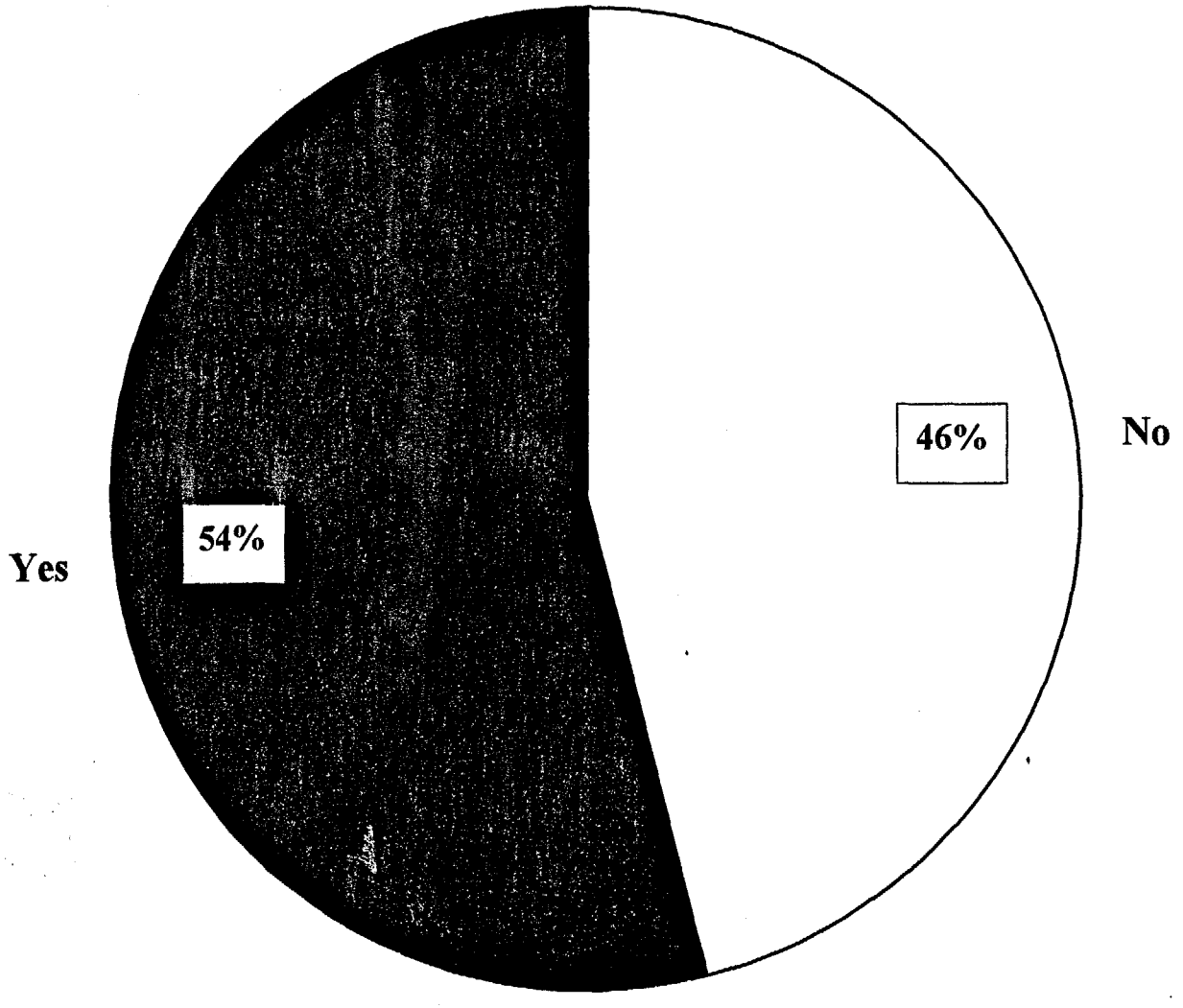
Yes No

a Health Care Consumer #6544

Q 29, Q 30

520

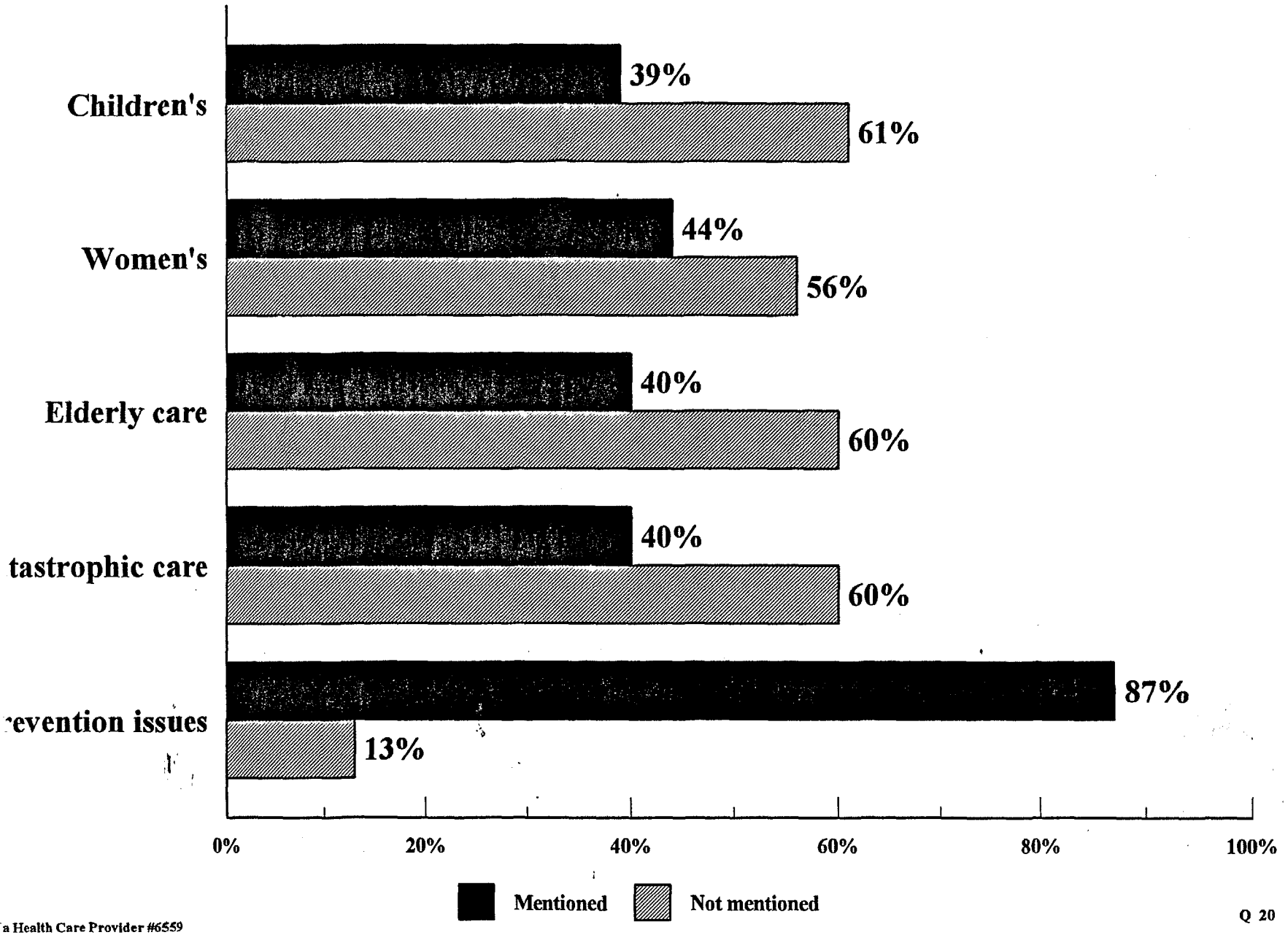
Public Health Campaign Participation



ssia Health Care Provider #6559

Q 19

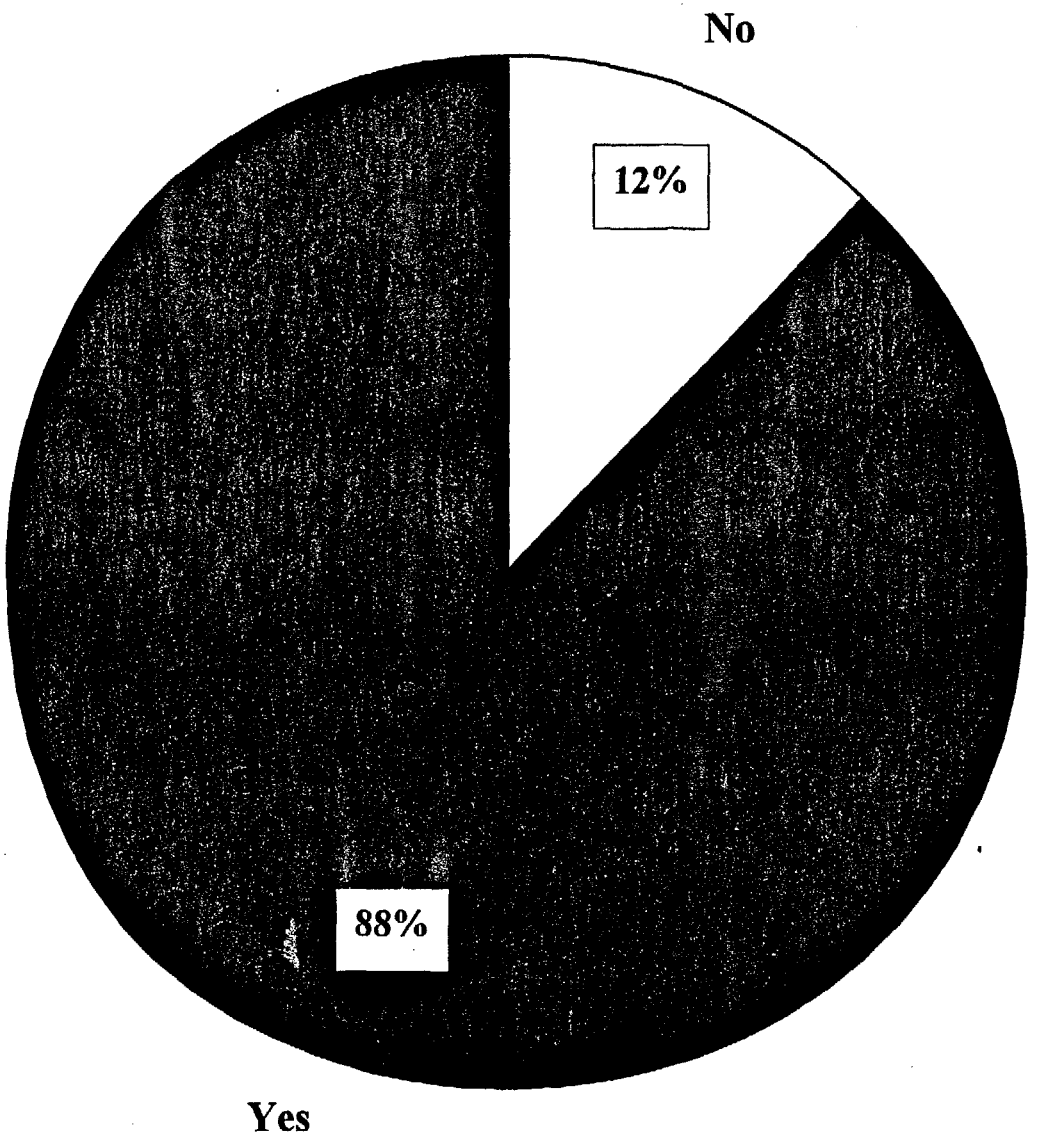
Health Issues Involved in...



a Health Care Provider #6559

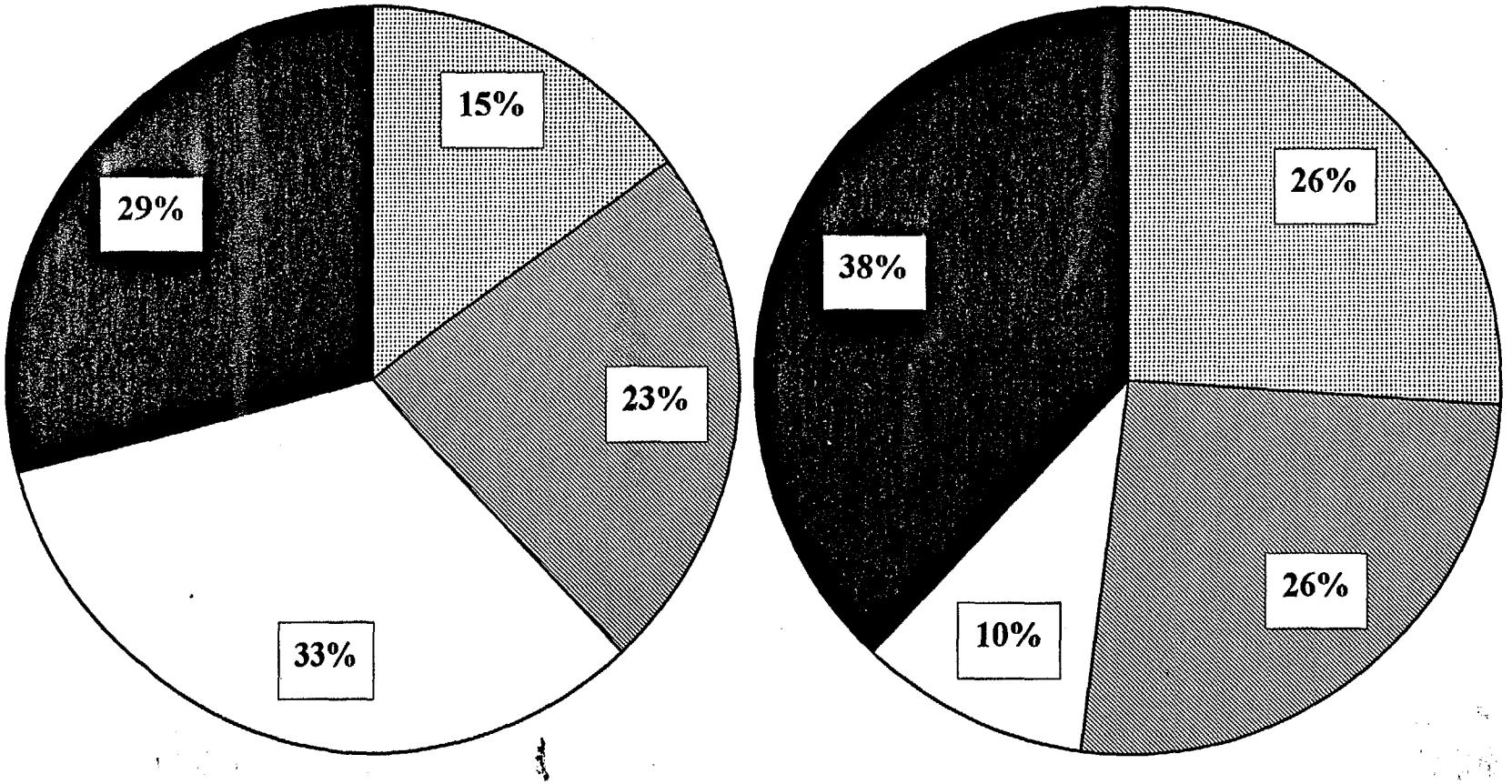
Q 20

een, Read, Heard about New Government Insurance Law



Will New Government Insurance System Improve Health Care

(Among those who had s/r/h)



Providers

Consumers

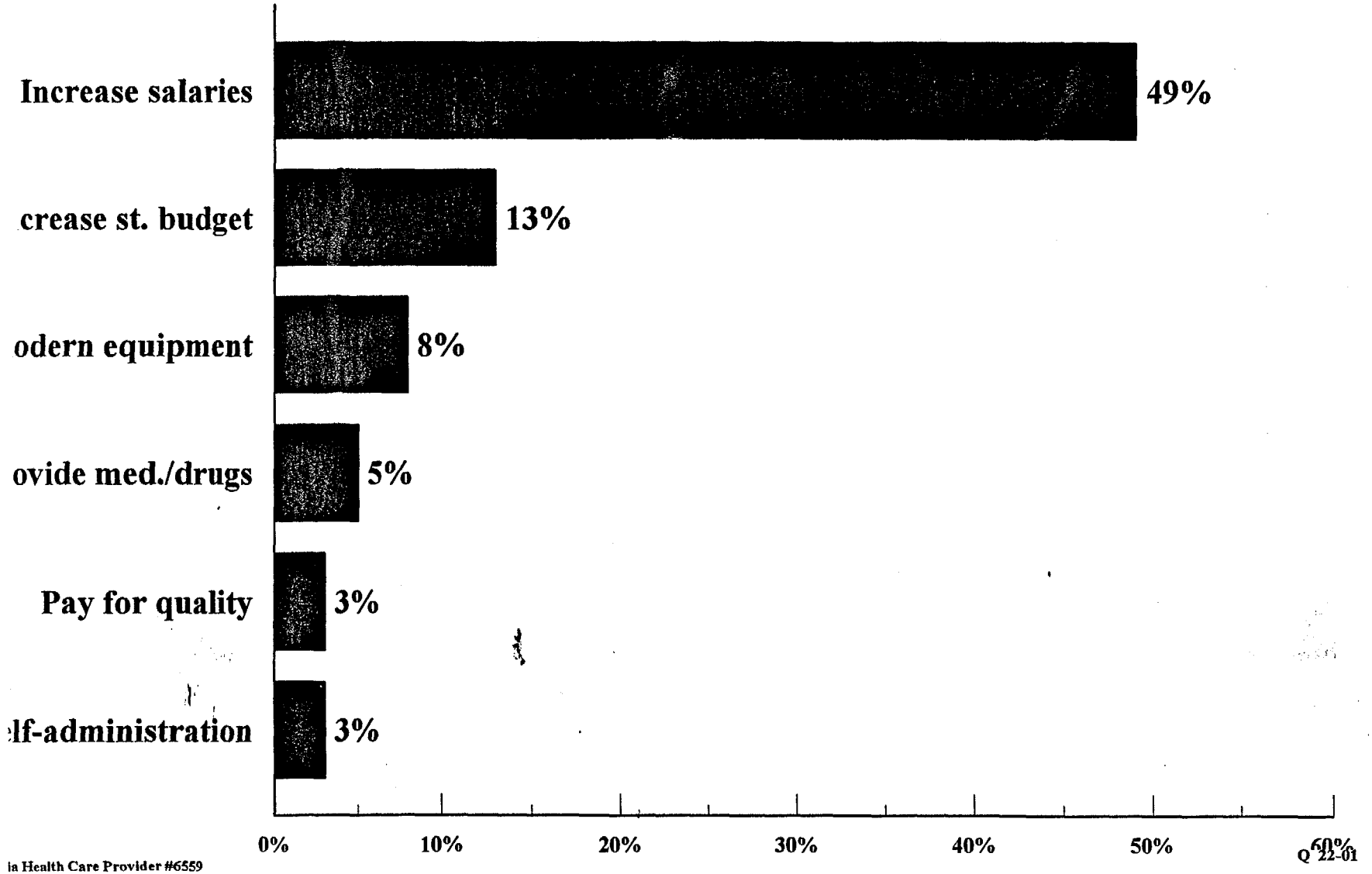
Improve | Worsen | No difference | Unsure

Q 9 Provider
Q 28 Consumer

asia Health Care Provider #6559

What Incentives should be Available?

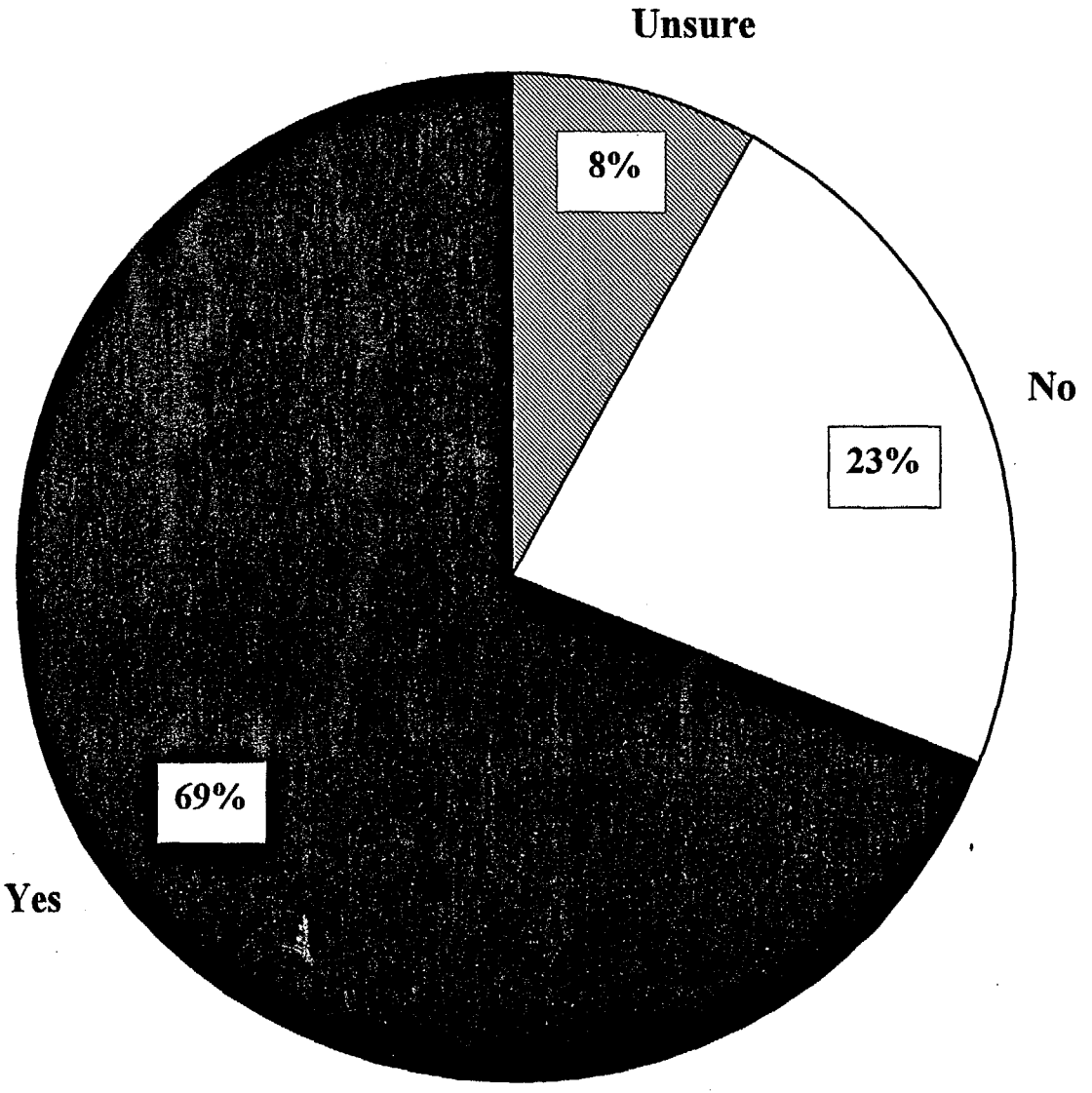
1st Choice
(Among no and unsure responses)



ia Health Care Provider #6559

Q 22-01

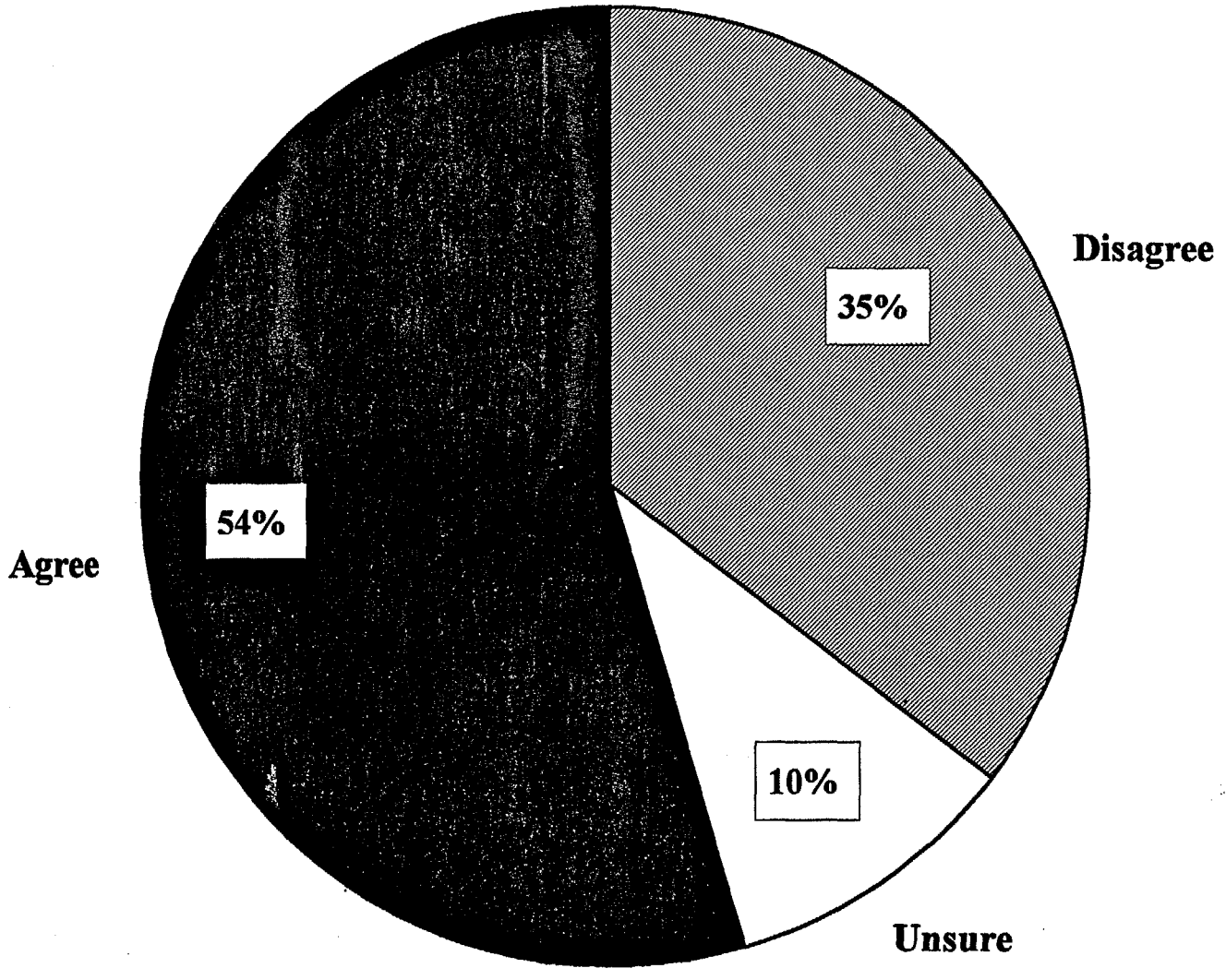
ould Competition Lead to Better Care and Lower Costs?



ia Health Care Provider #6559

Q 23

Current Health Care System is Good, Problems are Temporary

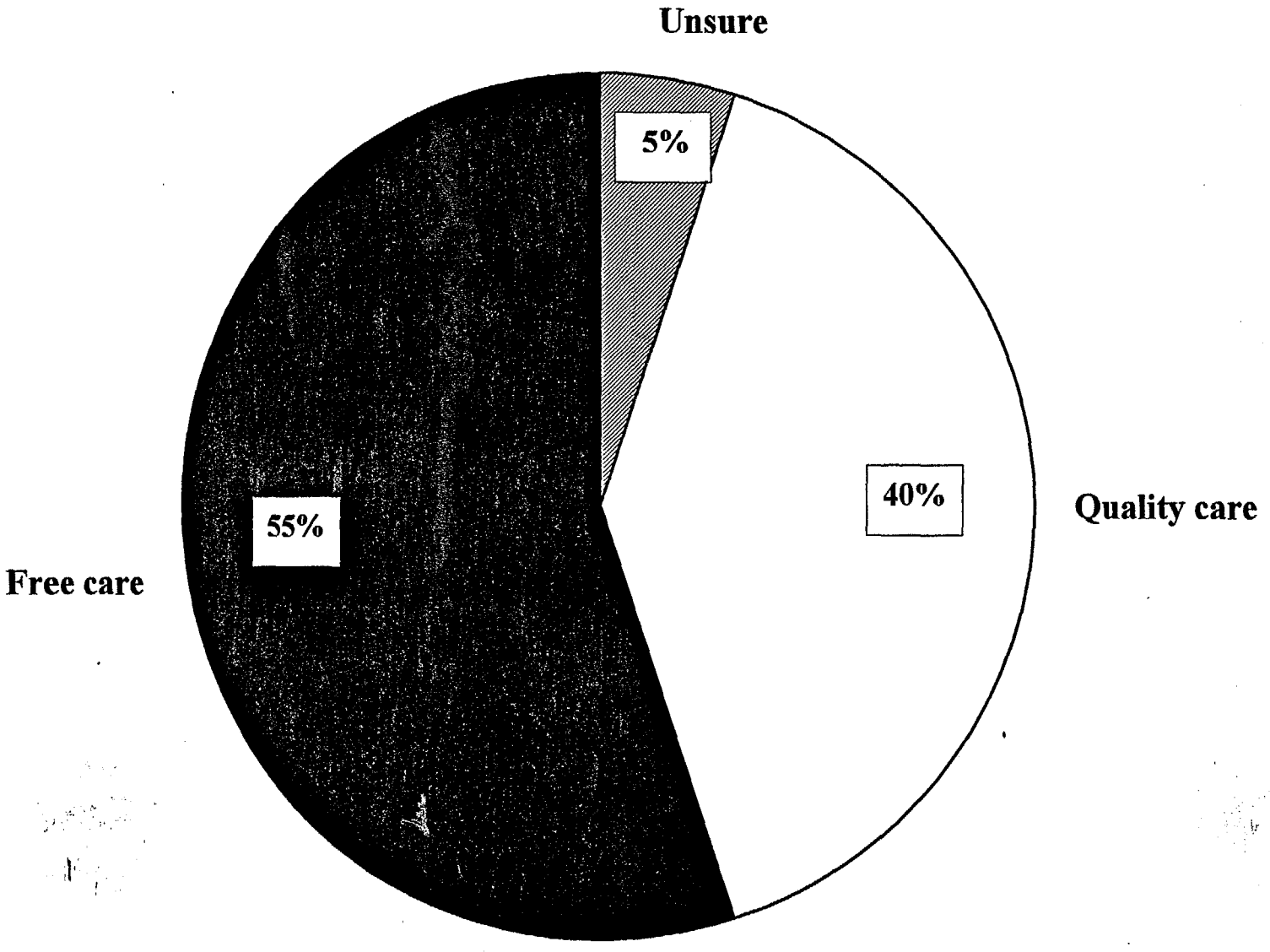


Russia Health Care Consumer #6544

Q 38

527

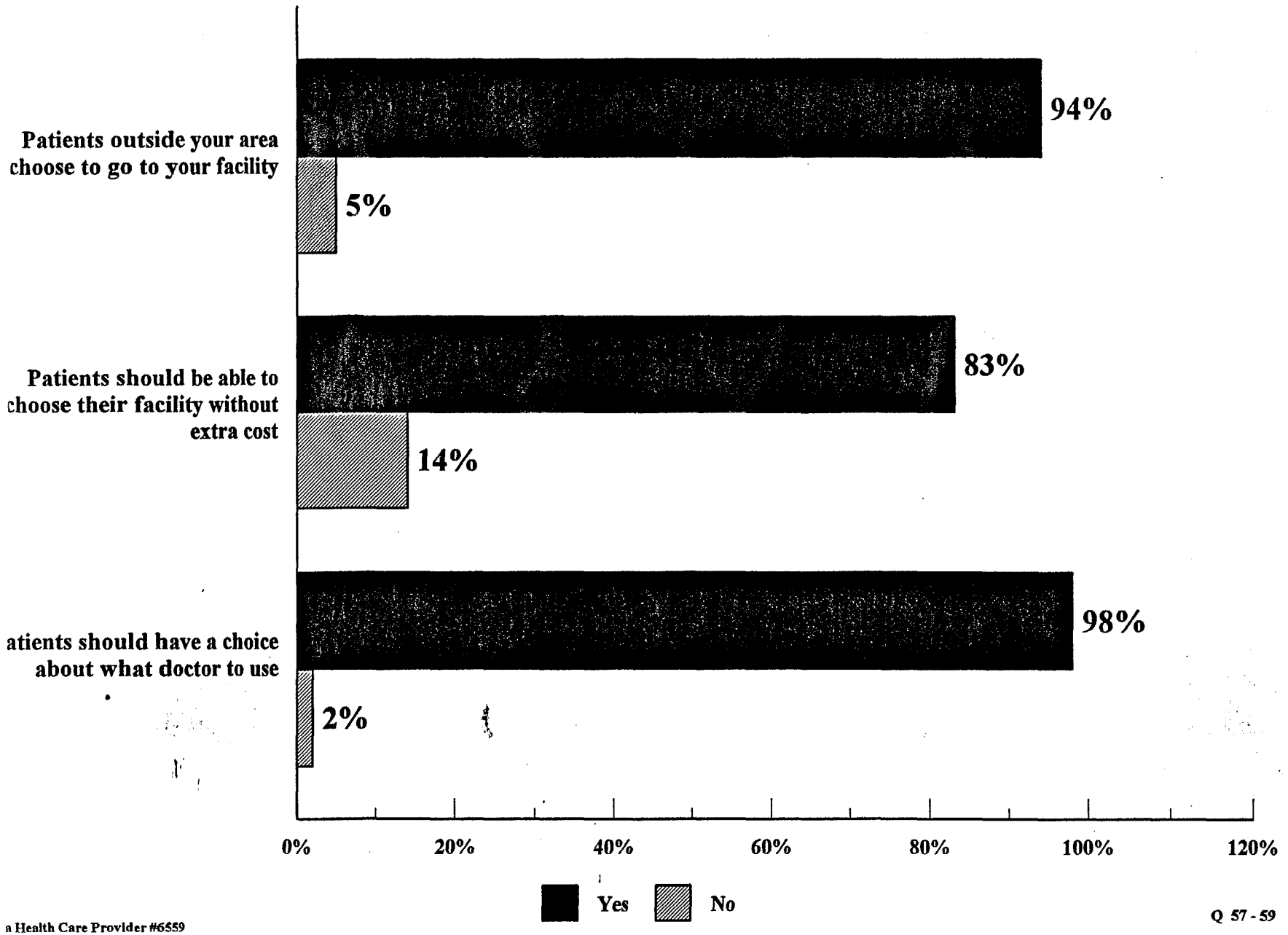
Medical Care Most Preferred



a Health Care Consumer #6544

Q 36

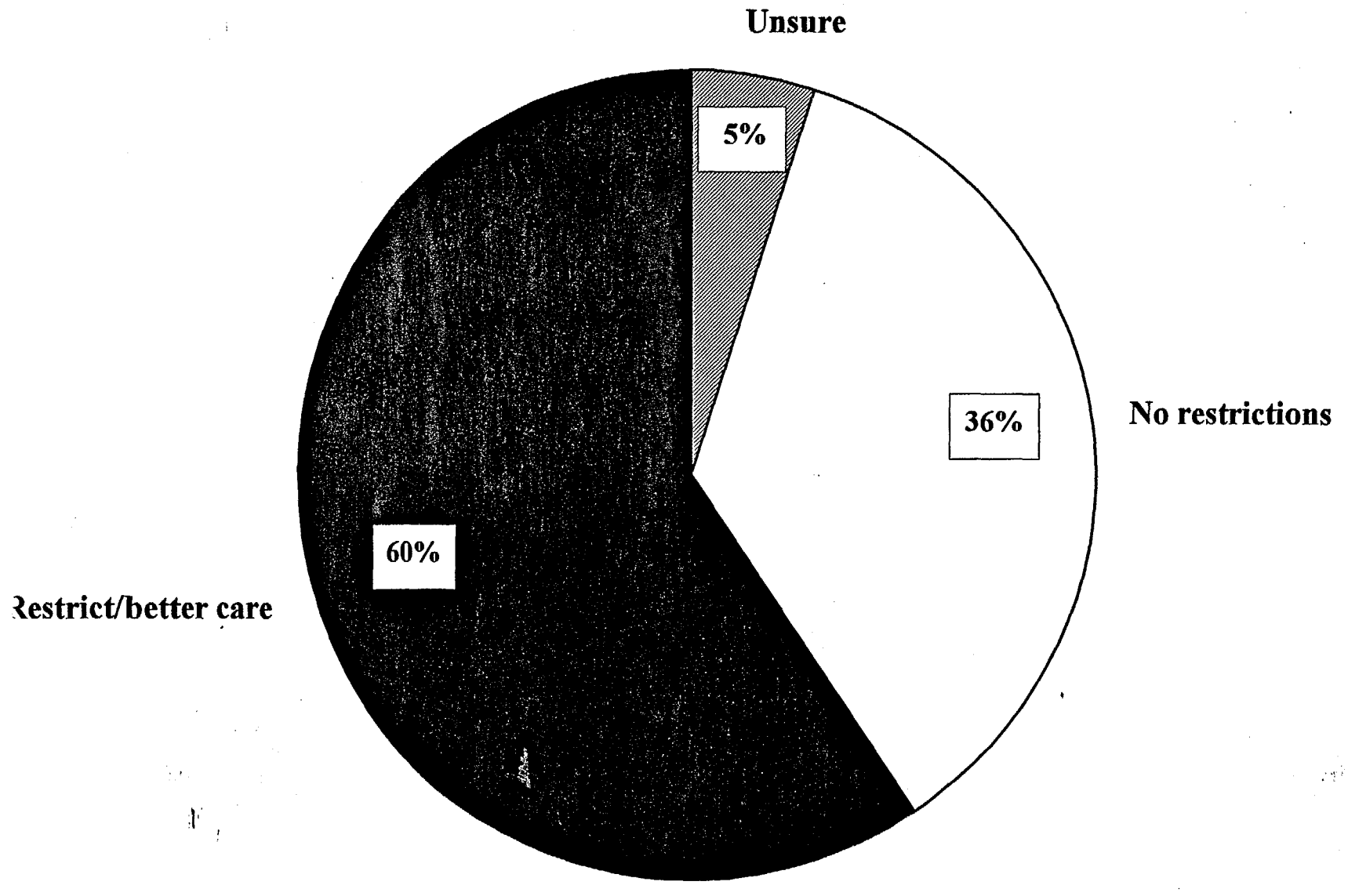
Patient's Choices in Facilities



a Health Care Provider #6559

Q 57 - 59

·efer Restrictions on Health Care to Guarantee Quality of Care

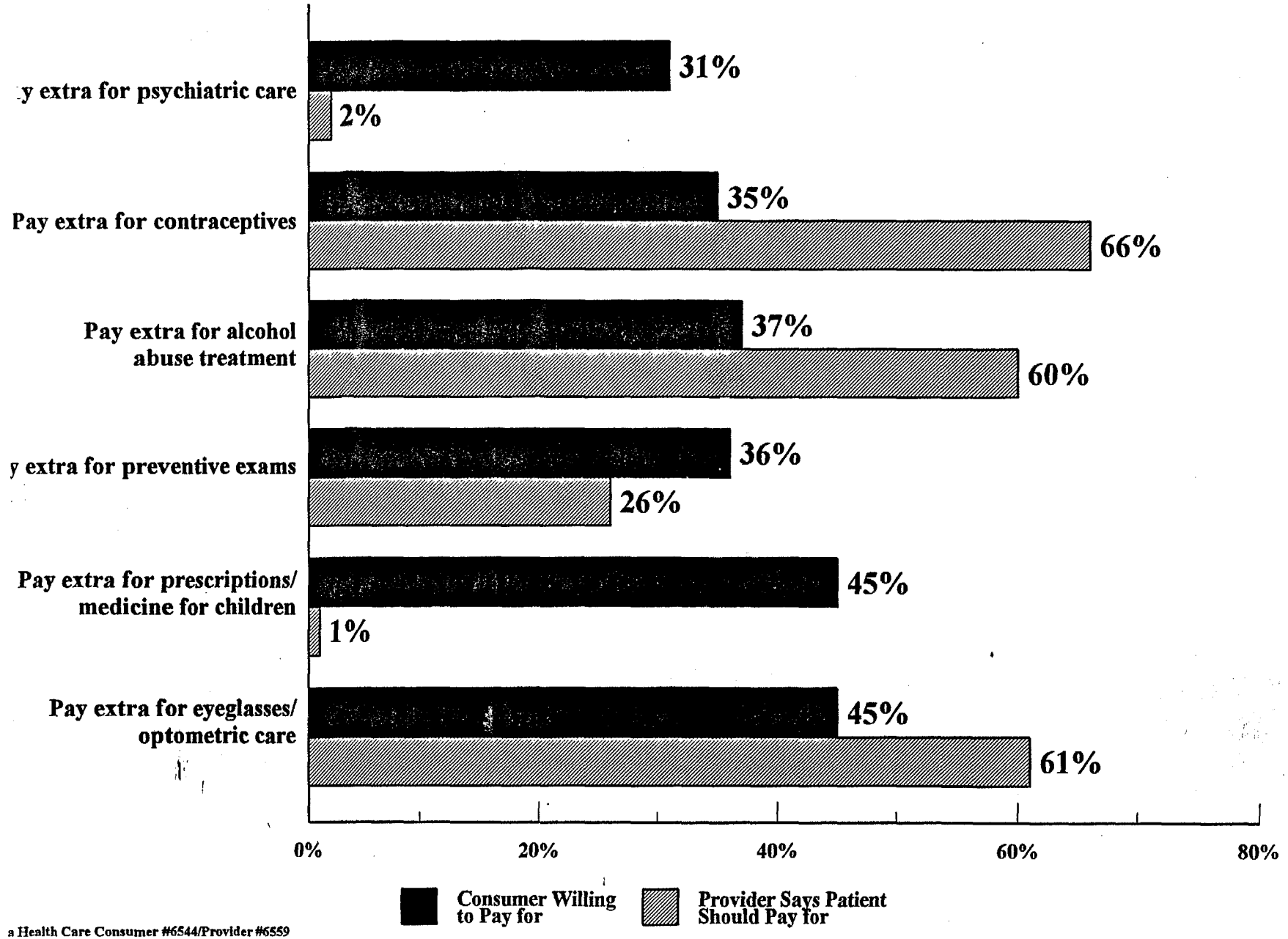


a Health Care Consumer #6544

Q 37

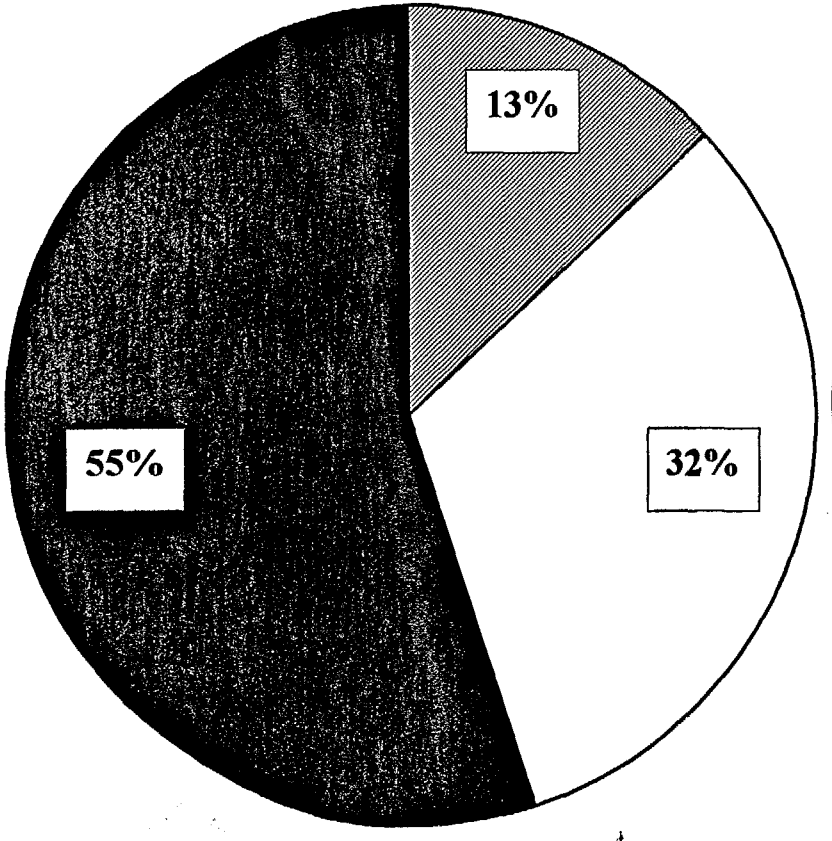
530

Willingness to Pay for Services

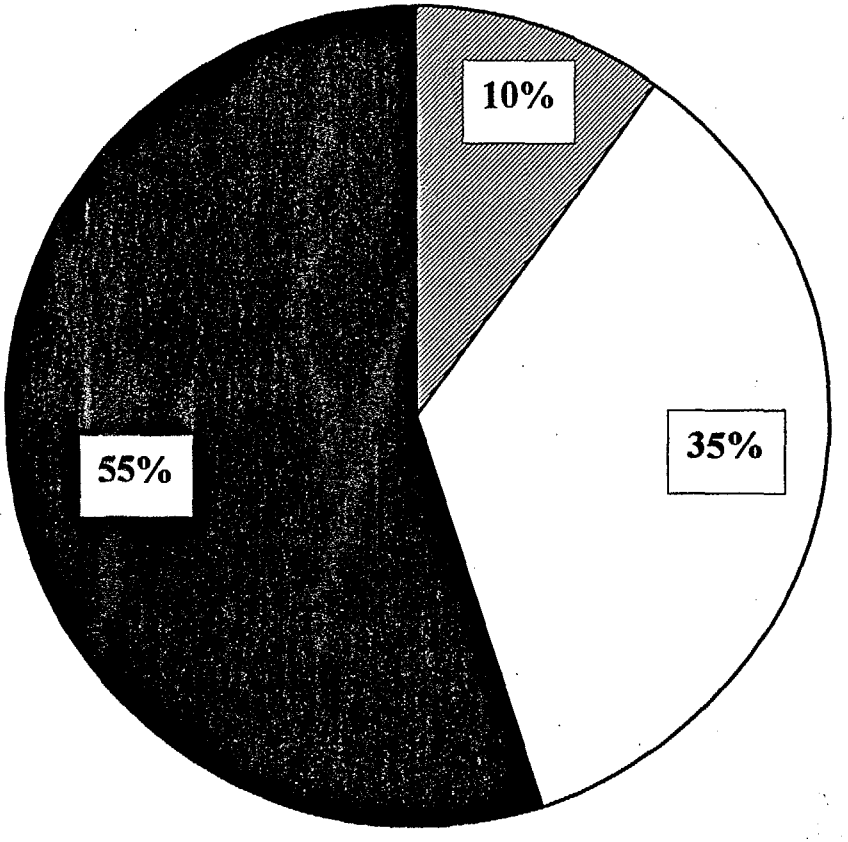


a Health Care Consumer #6544/Provider #6559

Privatization Choices



Willing to go to a non-profit health trust



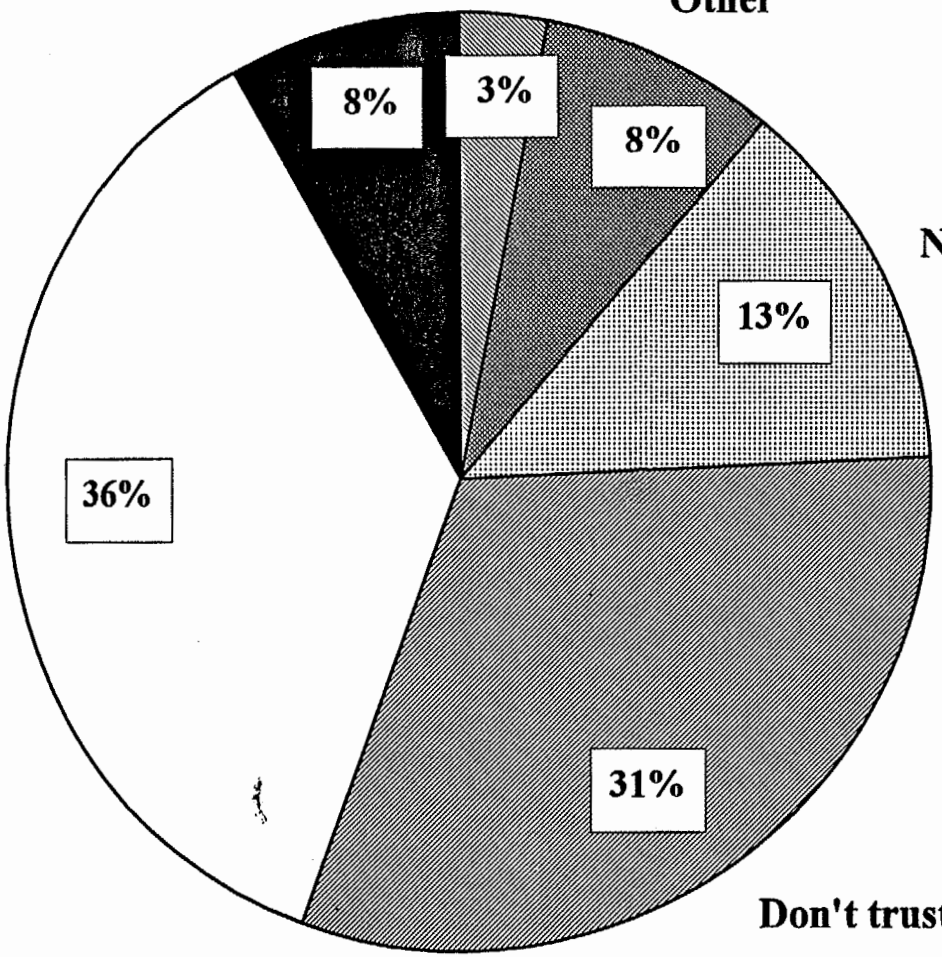
Willing to go to a for profit private hospital or clinic

Willing | Not willing | Unsure

Health Care Consumer #6544

Q 47, Q 48

Why not go to a Private Hospital or Clinic?
(among those not willing to go to private hospital/clinic)

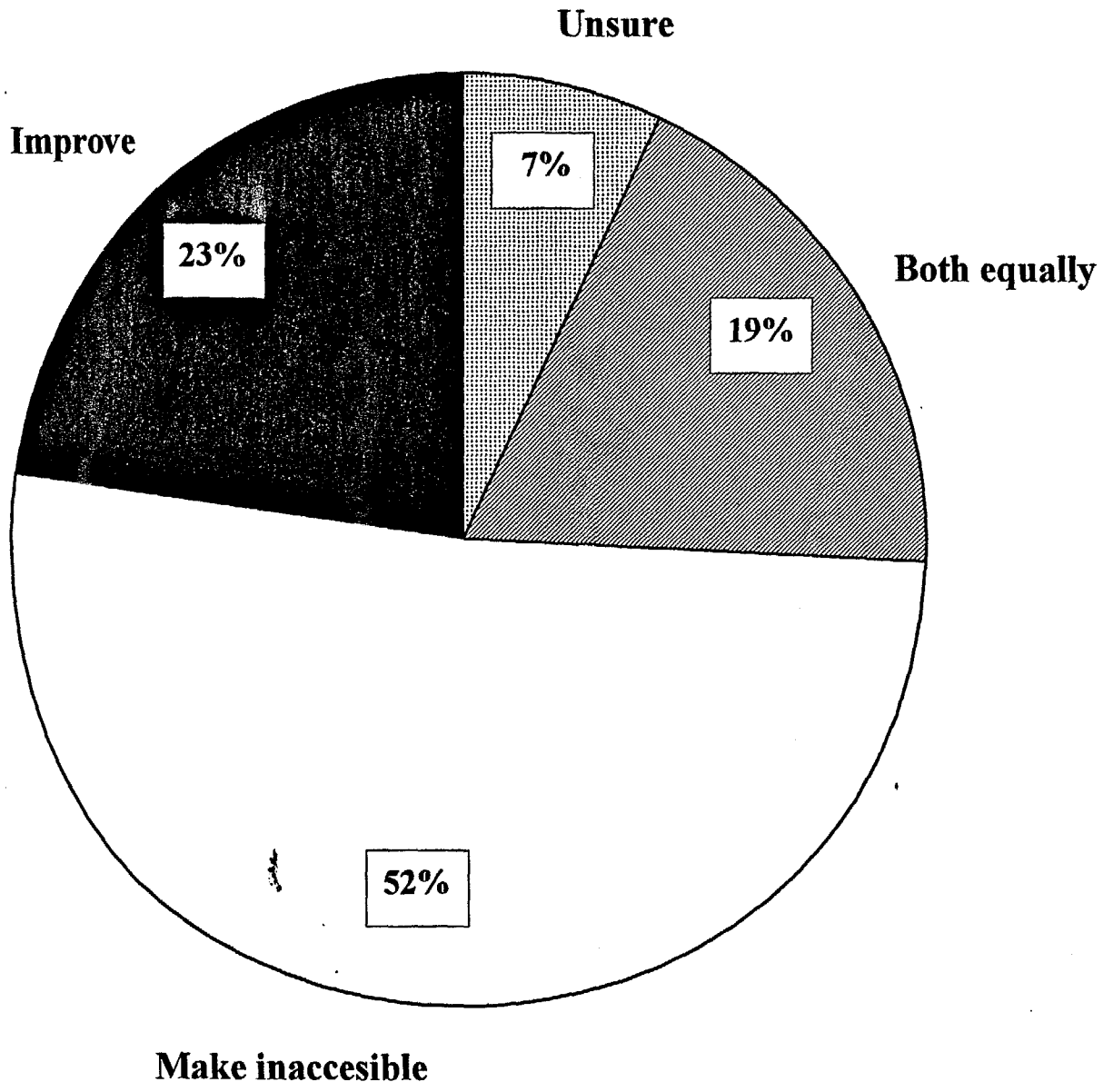


Health Care Consumer #6544

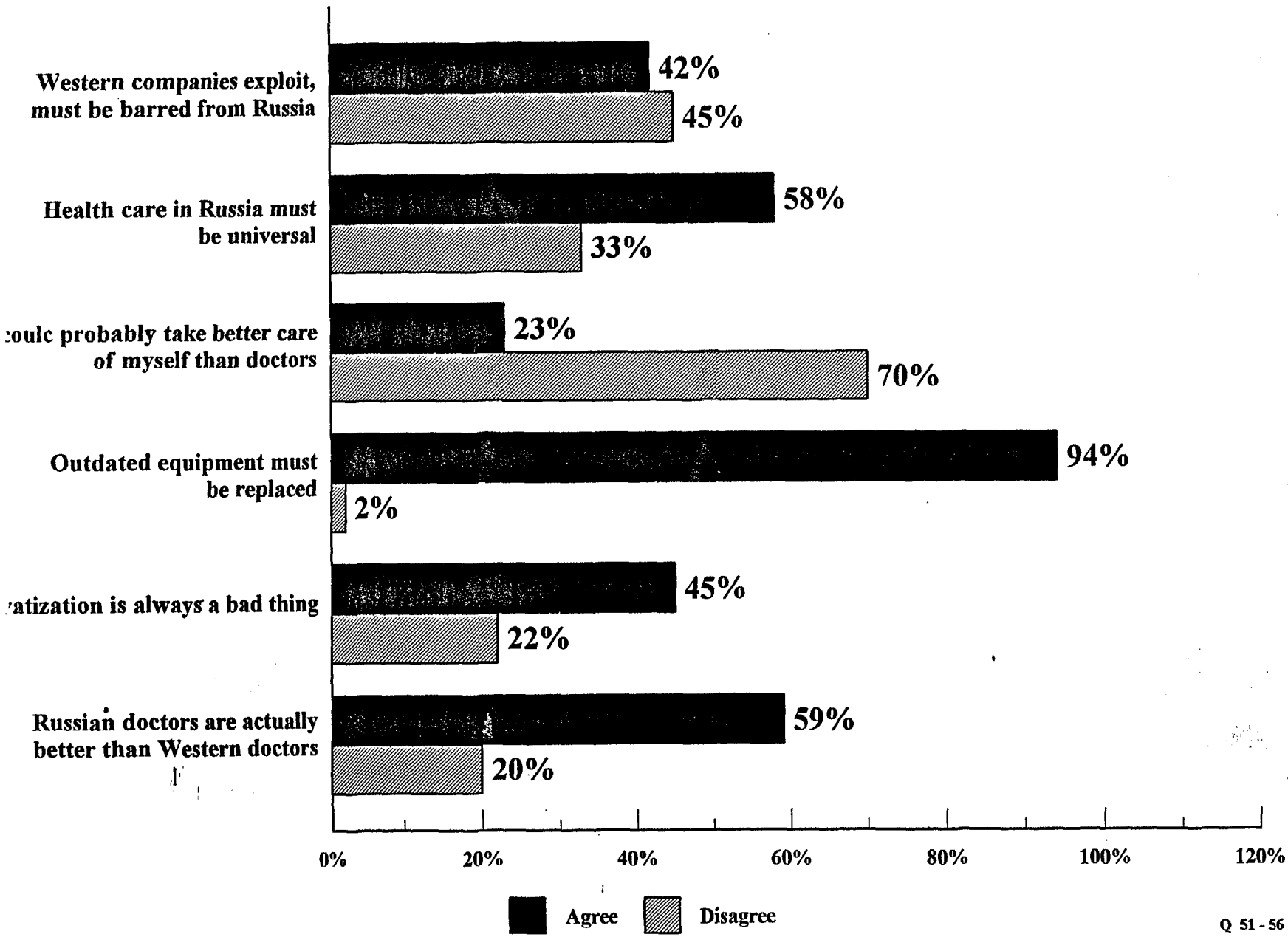
Q 49

33

View if Business Runs Health Care, It Will...



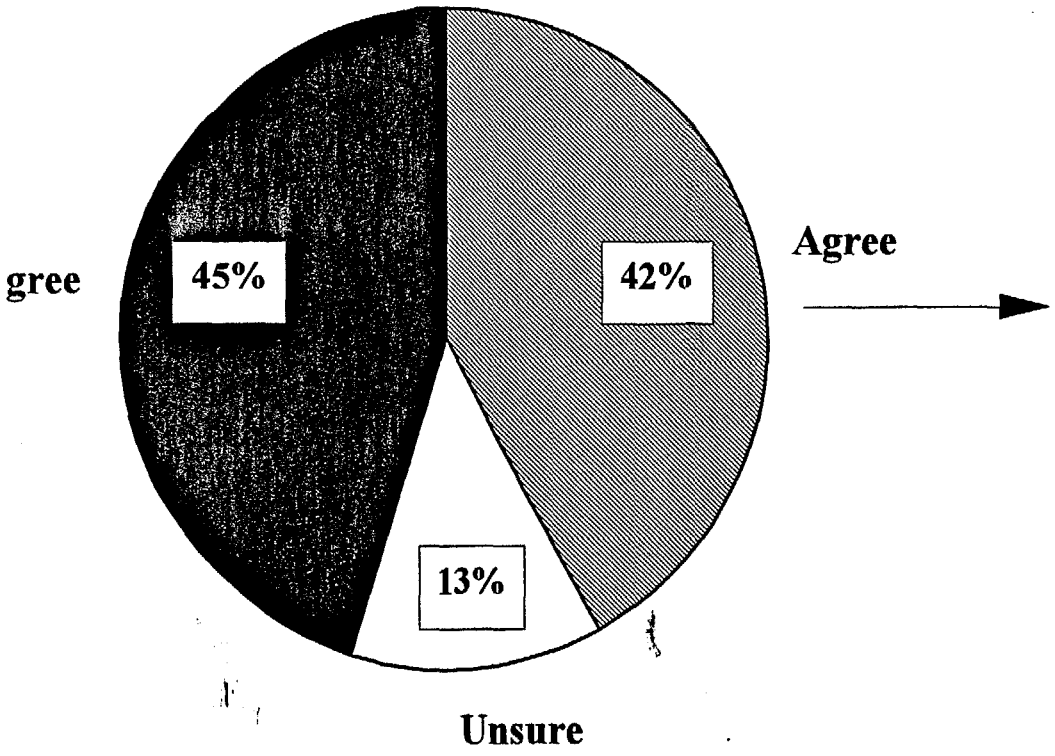
Views on Health Care



Q 51 - 56

a Health Care Consumer #6544

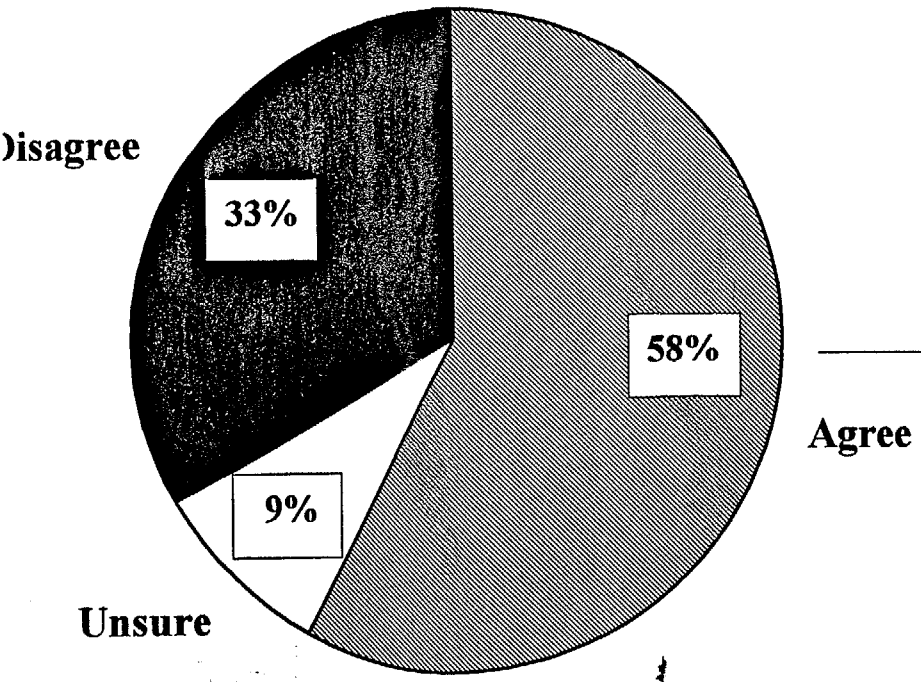
'ESTERN PHARMACEUTICAL COMPANIES ARE EXPLOITATIVE AND SHOULD BE BARRED



KEY GROUPS

• Older men	49%
• Blue collar workers	47%
• Low income respondents	48%
• Think health care system is going to deteriorate	48%

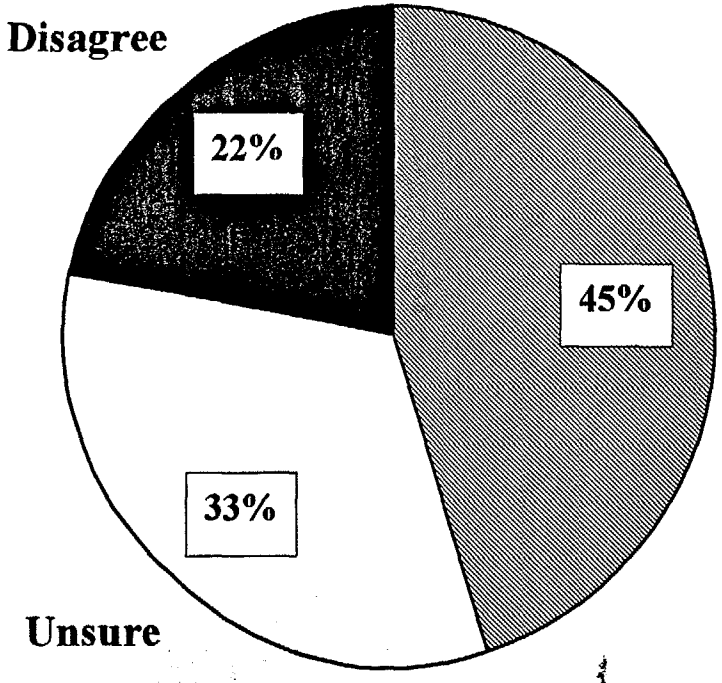
RUSSIAN SYSTEM MUST BE UNIVERSAL



KEY GROUPS

• Under 35 years of age	43%
• 45-54 year olds	64%
• 55-64 year olds	71%
• Seniors	75%

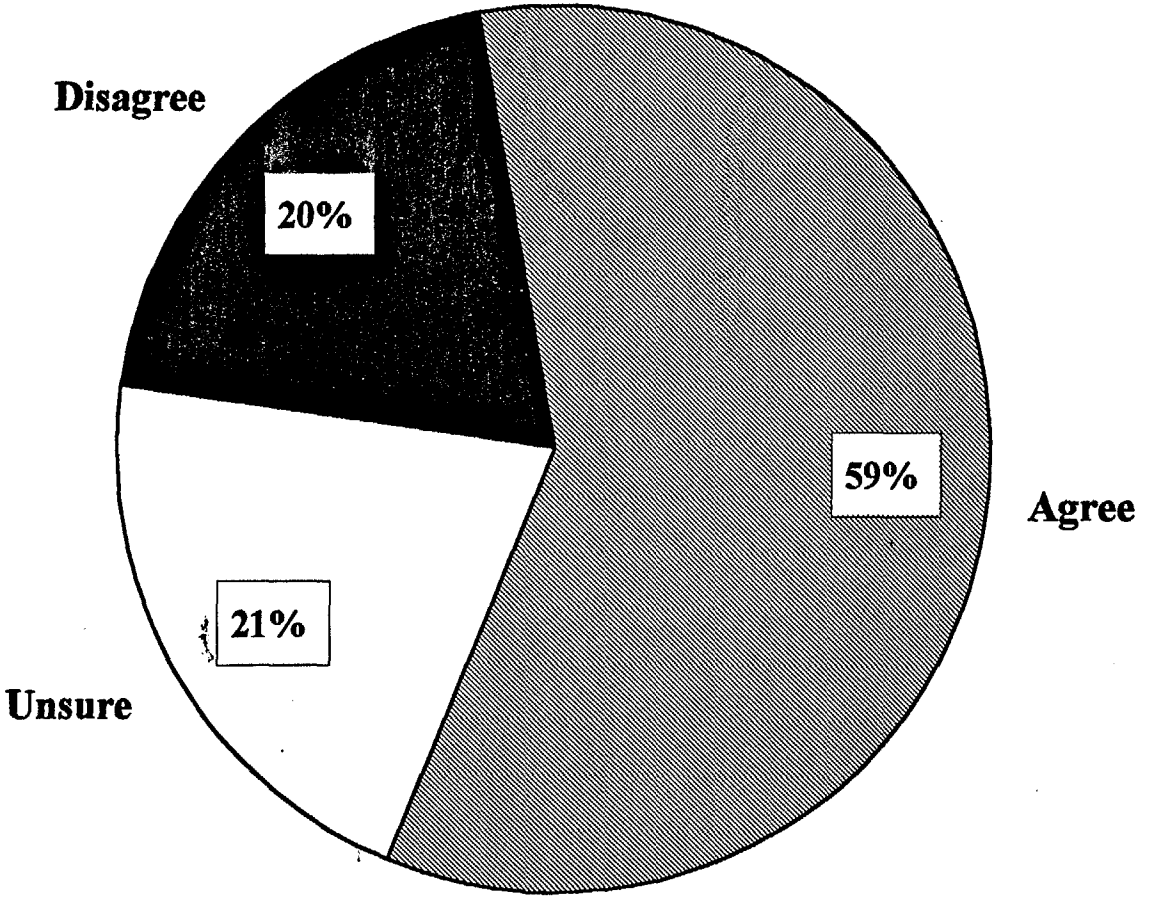
'RIVATIZATION IS ALWAYS A BAD THING



KEY GROUPS

• Cities with over half a million people	52%
• Ural/Siberia region	51%
• 45-54 year olds	54%
• Blue collar workers	50%
• Predict health care system will get worse in the next ten years	53%

RUSSIAN DOCTORS BETTER THAN WESTERN DOCTORS, BECAUSE THEY CARE FOR PEOPLE EVEN WITHOUT MODERN DRUGS AND EXPENSIVE EQUIPMENT



REFORM TARGET GROUP II

SATISFIED/REFORM RESISTANT - 11%

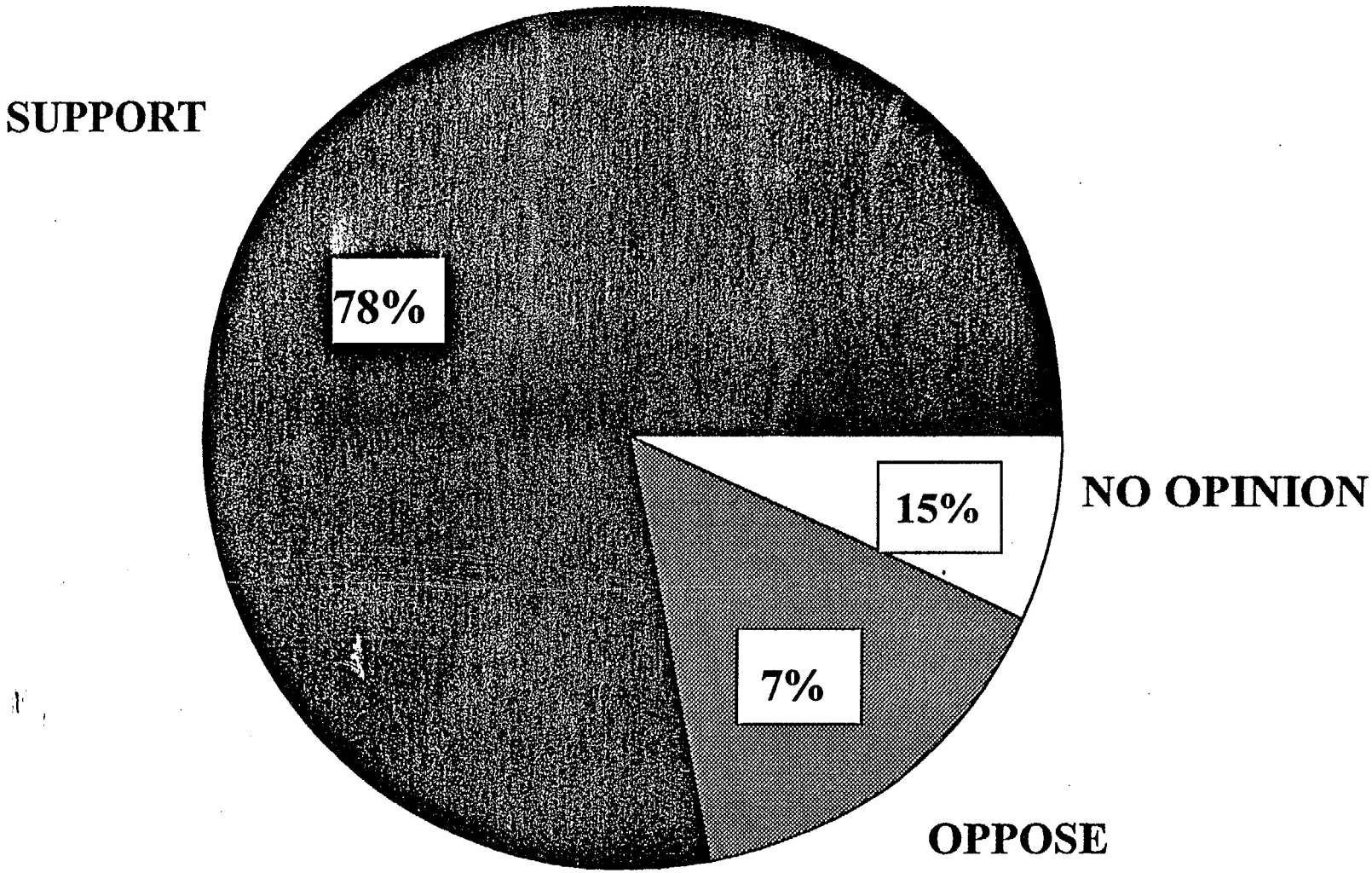
- Central/Northern Russia
- Urban, although not in the largest cities
- 65 years of age and over
- Women over the age of 45
- Retired
- Resistance increases as education level decreases
- Resistance increases as income level decreases
- Place a premium on free medical care

REFORM TARGET GROUP I

DISSATISFIED/MORE OPEN TO REFORM - 46%

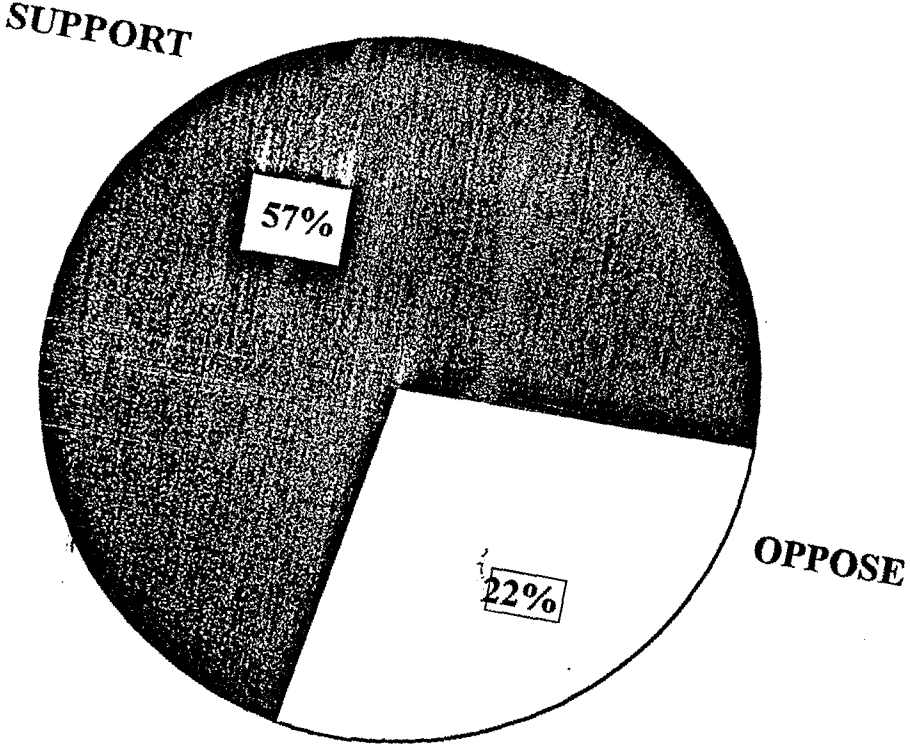
- Ural/Siberia or Far East Regions
- Towns with less than 10,000 people
- 18-34 year olds
- Women under the age of 45
- Have children
- College or technical school education
- "White collar" worker
- Think health care system problems are inherent, not temporary
- Used unpaid and paid medical care in the past two years

HEALTH TRUST SYSTEM

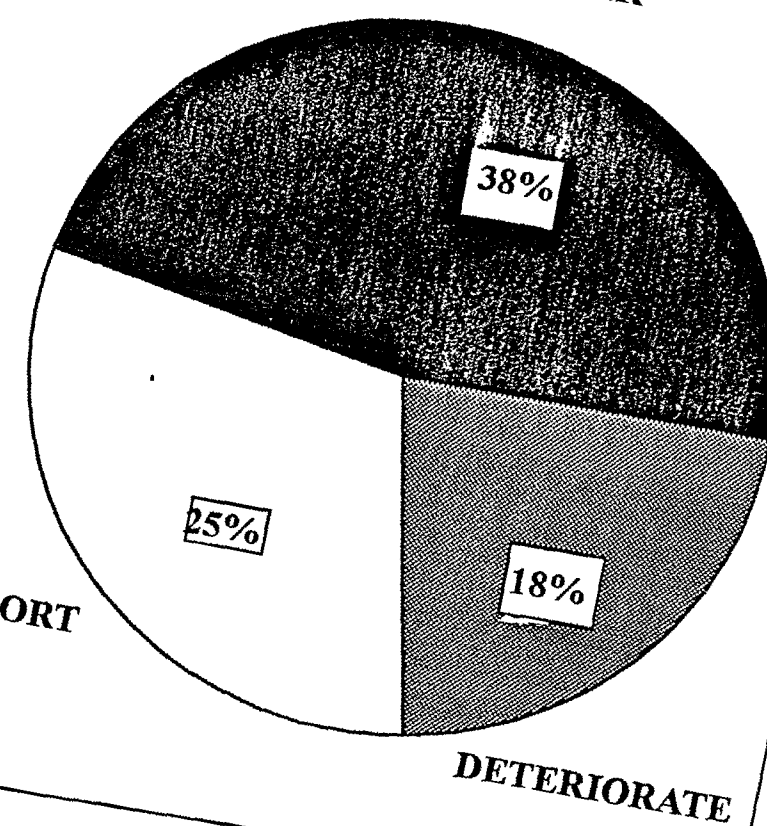


REFORM SYSTEMS

GOVERNMENT CONTRIBUTES TO INSURANCE COMPANIES



IMPACT ON FACILITY



PUBLIC EDUCATION CAMPAIGN

- FUTURE-ORIENTED
- FOCUS ON CHOICE
- MOBILIZE MEDICAL COMMUNITY TOWARD COMPETITION
- REINFORCE UNIVERSAL FREE CARE
- REFINE LIST OF FREE/PAID SERVICES
- ORIENT CAMPAIGN TOWARDS POLYCLINICS AND PREVENTATIVE EDUCATION

Код	Ввод

Институт сравнительных социальных исследований
117218, Москва, ул. Кржижановского, 24/35, к. 5
тел. 095/128-56-01

Документ ЦЕССИ/С94053
Анкета N _____
Город/село опроса
_____

Проблемы медицины в России: май 1994

****

ИНТЕРВЬЮЕР, ДАЛЕЕ ВАМ В СООТВЕТСТВИИ С ИНСТРУКЦИЯМИ К НЕКОТОРЫМ ВОПРОСАМ ПРИДЕТСЯ МЕНЯТЬ ПОРЯДОК ЧТЕНИЯ АЛЬТЕРНАТИВ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА, С КОТОРЫМ ВЫ ГОВОРИТЕ. ОТМЕТЬТЕ ЗДЕСЬ КАКОГО ПОРЯДКА ЧТЕНИЯ ВЫ БУДЕТЕ ПРИДЕРЖИВАТЬСЯ ДЛЯ ДАННОГО РЕСПОНДЕНТА. ДЛЯ ПЕРВОГО РЕСПОНДЕНТА ПОРЯДОК ЧТЕНИЯ ВСЕГДА ТАКОЙ КАК НАПЕЧАТАН В АНКЕТЕ

1. КАК НАПЕЧАТАН В АНКЕТЕ 2. ОБРАТНЫЙ ПОРЯДОК

Сначала несколько вопросов о ситуации в России в целом

1. Как Вы считаете, дела в России движутся в правильном направлении или они в значительной степени пошли по неправильному пути?

ЕСЛИ ВЫБОР СДЕЛАН, СПРОСИТЕ: Вы в этом совершенно уверены?

(1) В правильном направлении, совершенно уверен
(2) В правильном направлении
(3) В неправильном направлении
(4) В неправильном направлении, совершенно уверен
(9) Затрудняюсь ответить

---

2. Теперь мне хотелось бы зачитать Вам список проблем, стоящих перед нашей страной в настоящее время. Пожалуйста, прослушайте этот список и скажите мне, какую одну из этих проблем Вы считаете наиболее важной для России сегодня? *(ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА. ВОЗМОЖЕН ОДИН ВЫБОР.)*

	Самая важная проблема
Политическое руководство страны	1
Межнациональные конфликты	2
Дефицит товаров и продуктов	3
Медицинское обслуживание	4
Преступность	5
Высокие цены	6
Безработица	7
Комбинация из перечисленного */НЕ ЧИТАТЬ/*	(8)
Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*	(9)

Давайте еще немного поговорим о том, как идут дела в России.

3. Скажите, пожалуйста, какую проблему Вы считаете проблемой номер один для Вас лично в настоящее время. Я имею ввиду, чем Вы лично (а может быть и вся Ваша семья) наиболее обеспокоены в настоящее время? *(ЗАПИШИТЕ ДОСЛОВНО ОТВЕТ РЕСПОНДЕНТА. ПОСТАРАЙТЕСЬ ПОЛУЧИТЬ КАК МОЖНО БОЛЕЕ КОНКРЕТНЫЙ ОТВЕТ)*

ЕСЛИ ОТВЕТ НЕ ЯСЕН, УТОЧНИТЕ: Что Вы имеете ввиду? Расскажите, пожалуйста, подробней о Вашей проблеме.

!_____!

!_____!

!_____!

!

Теперь я собираюсь зачитать Вам названия некоторых организаций, действующих в России, а Вы, пожалуйста, скажите мне, как бы Вы оценили работу каждой из этих организаций в настоящее время - как отличную, хорошую, удовлетворительную или неудовлетворительную? */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

	Отличная	Хорошая	Удовлетворительная	Неудовлетворительная	(Затрудняюсь ответить) (НЕ ЧИТАТЬ)
4. Министерство здравоохранения ПОВТОРИТЕ: Считаете ли Вы его работу отличной, хорошей, удовлетворительной или неудовлетворительной?	1	2	3	4	(9)
5. Государственная Дума	1	2	3	4	(9)
6. Госкомимущество	1	2	3	4	(9)

Давайте поговорим о Вашей районной поликлинике

7. Скажите, пожалуйста, насколько Вы удовлетворены или не удовлетворены тем, как Ваша поликлиника обеспечивает медицинское обслуживание людей, живущих в Вашем районе?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы полностью удовлетворены/не удовлетворены или лишь частично удовлетворены/не удовлетворены?

(1) Полностью удовлетворен
(2) Частично удовлетворен
(3) Частично не удовлетворен
(4) Полностью не удовлетворен
(9) Затрудняюсь ответить/нет мнения

Следующий вопрос о Вашем областном отделе здравоохранения.

8. Скажите, пожалуйста, Вы удовлетворены или не удовлетворены тем, как Ваш областной отдел здравоохранения обеспечивает медицинское обслуживание людей, живущих в Вашей области?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы полностью удовлетворены/не удовлетворены или лишь частично удовлетворены/не удовлетворены?

(1) Полностью удовлетворен
(2) Частично удовлетворен
(3) Частично не удовлетворен
(4) Полностью не удовлетворен
(9) Затрудняюсь ответить/нет мнения

Следующий вопрос о Вашем здоровье

9. Скажите, пожалуйста, как Вы оцениваете состояние Вашего здоровья в настоящее время - как отличное, хорошее, удовлетворительное или плохое? */НЕ ЧИТАТЬ/*

(1) Отличное
(2) Хорошее
(3) Удовлетворительное
(4) Плохое
(9) Затрудняюсь ответить/нет мнения

---

10. Скажите, пожалуйста, за последние два года приходилось ли Вам лично или кому-либо из членов Вашей семьи обращаться за бесплатной медицинской помощью (может быть, в Вашу районную поликлинику или куда-либо еще) или не приходилось?

(1) Да, приходилось -->*К ВОПРОСАМ 11-14*
(2) Нет, не приходилось -->*К ВОПРОСУ 15*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 15*

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ЕСЛИ "ДА" НА ВОПРОС 10, СПРОСИТЕ:

11. Давайте поговорим теперь о последнем случае, когда Вы лично обращались за бесплатной медицинской помощью. Если за последние два года Вы лично к врачу не обращались, а это делал кто-либо из членов Вашей семьи, то вспомните о последнем случае посещения врача членом Вашей семьи. В какое медицинское учреждение Вы или кто-либо из членов Вашей семьи обращались в последний раз? */ЗАЧИТАЙТЕ/*

    1. В больницу
    2. В поликлинику
    3. Посещение врача на дому
    4. К лекарю, знахарю, непрофессиональному врачу
    (8) Другое */КУДА ИМЕННО/* _____
    (9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

---

12. По поводу какого заболевания Вы обращались к врачу и в какого рода помощи Вы нуждались в последний раз. Если Вы не посещали врача за последние два года, а это делал кто-либо из членов Вашей семьи, то за какой помощью обращался к врачу кто-либо из членов Вашей семьи в последний раз? */НЕ ЧИТАТЬ. ЗАПИШИТЕ СО СЛОВ/*

    (01) Хирургическая помощь
    (02) Перелом кости (ноги, ребра, бедра и т.д.)
    (03) Скорая помощь, помощь во время несчастного случая
    (04) Общее обследование
    (05) Педиатрическая помощь
    (06) Рождение ребенка, наблюдение во время беременности
    (07) Прививки
    (08) Помощь при раковом заболевании
    (09) Пневмония, бронхит, воспаление легких
    (10) Сердечный приступ, кардиографическая помощь
    (11) Измерение давления, помощь от давления, высокое давление
    (12) Паралич, удар
    (13) Диабет
    (14) Неврологические проблемы
    (15) Желудочное заболевание, язва, воспаление желчного пузыря
    (16) Артрит
    (17) Инфекционное заболевание
    (18) Рентгеновское обследование
    (19) Гериатрические проблемы
    (20) Зубная боль, протезирование
    (21) Простудное заболевание, грипп
    (98) Другое */ЧТО ИМЕННО/* _____
    (99) Затрудняюсь ответить, отказ от ответа

---

13. Приходилось ли Вам лично предлагать подарки или каким-либо другим образом платить врачу или мед.сестрам за оказанные услуги или не приходилось? */НЕ ЧИТАТЬ/*

    (1) Да, приходилось
    (2) Нет, не приходилось
    (9) Затрудняюсь ответить/нет мнения

---

14. Как бы Вы оценили качество медицинской помощи, которую Вы получили? Могли бы Вы сказать, что оно: */ЗАЧИТАЙТЕ/*

    1. Отличное
    2. Хорошее
    3. Удовлетворительное
    4. Плохое
    (9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

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СПРОСИТЕ ВСЕХ

15. Приходилось ли Вам или кому-либо из членов Вашей семьи обращаться за платной медицинской помощью за последние два года?

(1) Да -->*К ВОПРОСАМ 16-18*
(2) Нет -->*К ВОПРОСУ 19*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 19*

ЕСЛИ "ДА" НА ВОПРОС 10, СПРОСИТЕ:

16. Давайте поговорим теперь о последнем случае, когда Вы лично обращались к платному врачу. Если Вы к нему не обращались, а это делал кто-либо из членов Вашей семьи, то вспомните о последнем случае посещения платного врача членом Вашей семьи. В какое медицинское учреждение Вы или кто-либо из членов Вашей семьи обращались? */ЗАЧИТАЙТЕ. ВОЗМОЖЕН ОДИН ОТВЕТ/*

1. В больницу
2. В поликлинику
3. Посещение врача на дому
4. К лекарю, знахарю, непрофессиональному врачу

(8) Другое */КУДА ИМЕННО/* _____
(9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

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17. По поводу какого заболевания Вы или кто-либо из членов Вашей семьи обращались к врачу в последний раз или какого рода помощь Вы хотели получить? */НЕ ЧИТАТЬ. ЗАПИШИТЕ СО СЛОВ/*

(01) Хирургическая помощь
(02) Перелом кости (ноги, ребра, бедра и т.д.)
(03) Скорая помощь, помощь во время несчастного случая
(04) Общее обследование
(05) Педиатрическая помощь
(06) Рождение ребенка, наблюдение во время беременности
(07) Прививки
(08) Помощь при раковом заболевании
(09) Пневмония, бронхит, воспаление легких
(10) Сердечный приступ, кардиографическая помощь
(11) Измерение давления, помощь от давления, высокое давление
(12) Паралич, удар
(13) Диабет
(14) Неврологические проблемы
(15) Желудочное заболевание, язва, воспаление желчного пузыря
(16) Артрит
(17) Инфекционное заболевание
(18) Рентгеновское обследование
(19) Гериатрические проблемы
(20) Зубная боль, протезирование
(21) Простудное заболевание, грипп
(98) Другое */ЧТО ИМЕННО/* _____
(99) Затрудняюсь ответить, отказ от ответа

17А. Приходилось ли Вам лично кроме платы медицинскому учреждению, предлагать подарки или каким-либо другим образом платить самому врачу или мед.сестрам за лечение в платном медицинском учреждении или нет? */НЕ ЧИТАТЬ/*

(1) Да, приходилось
(2) Нет
(9) Затрудняюсь ответить/нет мнения

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18. Как бы Вы оценили качество медицинской помощи, которую Вы получили в платном медицинском учреждении? Могли бы Вы сказать, что оно было: */ЗАЧИТАЙТЕ/*

1. Отличное
2. Хорошее
3. Удовлетворительное
4. Плохое

(9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

18А. Почему Вы обратились не за бесплатной, а за платной медицинской помощью? */НЕ ЧИТАТЬ. КОДИРУЙТЕ СО СЛОВ НЕ БОЛЕЕ ТРЕХ ОТВЕТОВ/*

(01) Бесплатные мед.учреждения не оказывают услуг, в которых я нуждался
(02) Находился далеко от места жительства, где прописан
(03) Не нужно ждать, чтобы записаться к врачу
(04) Не нужно ждать на приеме у врача
(05) Лучше техническое оснащение
(06) Платные врачи более квалифицированы
(07) Более вежливое, внимательное обращение
(98) Другое */ЧТО ИМЕННО ИМЕННО/*__ _____
(99) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

СПРОСИТЕ ВСЕХ

19. Скажите, пожалуйста, насколько Вы удовлетворены медицинским помощью, которую Вы получаете в настоящее время? Можете ли Вы сказать, что Вы ей совершенно удовлетворены, очень удовлетворены, довольно удовлетворены или совершенно не удовлетворены? */НЕ ЧИТАТЬ/*

(1) Совершенно удовлетворены -->*К ВОПРОСУ 20*
(2) Очень удовлетворены -->*К ВОПРОСУ 20*
(3) Довольно удовлетворены -->*К ВОПРОСУ 19А*
(4) Совершенно не удовлетворены -->*К ВОПРОСУ 19А*
(5) Не пользовался медицинской помощью -->*К ВОПРОСУ 20*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 20*

19А. Пожалуйста, назовите мне две или три наиболее важные причины, почему Вы не полностью или совершенно не удовлетворены медицинским помощью, которое Вы получаете? *(ЗАПИШИТЕ ДОСЛОВНО ОТВЕТ РЕСПОНДЕНТА. ПОСТАРАЙТЕСЬ ПОЛУЧИТЬ КАК МОЖНО БОЛЕЕ КОНКРЕТНЫЙ ОТВЕТ)*

!_____!

!_____!

!_____!

!_____!

СПРОСИТЕ ВСЕХ

20. Скажите, пожалуйста, по-Вашему мнению, в следующие десять лет медицинское обслуживание в России станет лучше, станет хуже или останется на том же уровне? */НЕ ЧИТАТЬ/*

(1) Станет лучше
(2) Станет хуже
(3) Останется на том же уровне
(9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

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21. Скажите, пожалуйста, насколько Вы уверены в том, что если Вы заболеете, лечащий Вас врач будет достаточно квалифицирован и сможет Вам помочь? Вы в этом совершенно уверены, очень уверены, довольно уверены или совершенно не уверены? */НЕ ЧИТАТЬ/*

(1) Совершенно уверен
(2) Очень уверен
(3) Довольно уверен
(4) Совершенно не уверен
(9) Затрудняюсь ответить/нет мнения

Теперь обратимся к обеспечению лекарствами в России в настоящее время

22. Из Вашего личного опыта, скажите, пожалуйста, за последние несколько месяцев обеспечение лекарствами стало лучше, стало хуже, осталось таким же или лекарств, по Вашему мнению, совсем нет в продаже? */НЕ ЧИТАТЬ/*

(1) Стало лучше
(2) Стало хуже
(3) Осталось таким же
(4) Совсем нет в продаже
(9) Затрудняюсь ответить/нет мнения

22A. Скажите, пожалуйста, за последний год случалось ли Вам лично сталкиваться с ситуацией, что Вам было необходимо приобрести лекарство для Вас лично или для кого-нибудь из членов Вашей семьи и у Вас были деньги, чтобы купить такое лекарство, но Вы не могли найти его в продаже или такое не случалось?

ЕСЛИ ДА, СЛУЧАЛОСЬ, УТОЧНИТЕ: Это случалось часто, иногда или только однажды? */НЕ ЧИТАТЬ/*

(1) Никогда не случалось
(2) Часто
(3) Иногда
(4) Лишь однажды
(9) Затрудняюсь ответить/нет мнения

22B. Скажите, пожалуйста, за последний год случалось ли Вам лично сталкиваться с ситуацией, что Вам было необходимо приобрести лекарство для Вас лично или для кого-нибудь из членов Вашей семьи и такое лекарство было в продаже, но у Вас не было денег, чтобы купить такое лекарство?

ЕСЛИ ДА, СЛУЧАЛОСЬ, УТОЧНИТЕ: Это случалось часто, иногда или только однажды? */НЕ ЧИТАТЬ/*

(1) Никогда не случалось
(2) Часто
(3) Иногда
(4) Лишь однажды
(9) Затрудняюсь ответить/нет мнения

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23. Как Вы считаете, качество лекарств, которые продают в России сегодня, лучше, хуже или такое же, как несколько лет назад?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Считаете ли Вы, что качество лекарств <u>гораздо</u> лучше/хуже или лишь <u>несколько</u> лучше/хуже, чем несколько лет назад?

(1) Гораздо лучше
(2) Несколько лучше
(3) Примерно такое же
(4) Несколько хуже
(5) Гораздо хуже
(9) Затрудняюсь ответить/нет мнения

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24. Если бы Ваша местная аптека стала продавать не только лекарства, но и другие товары, такие как косметику или средства ухода за собой, Вы лично стали бы покупать эти товары в аптеке или продолжали бы покупать их там, где Вы покупаете их сейчас? */НЕ ЧИТАТЬ/*

(1) Стал бы покупать в аптеке
(2) Покупал бы там же, где покупаю сейчас
(3) Покупал бы и там и там
(4) Нигде не покупаю таких товаров
(9) Затрудняюсь ответить/нет мнения

Теперь вопрос о будущем медицинского обслуживания в России.

25.1. Насколько Вы лично обеспокоены тем, что Вам, возможно, придется платить за медицинское обслуживание Вас и членов Вашей семьи? Вас лично это: */ЗАЧИТАЙТЕ/*

1. Очень беспокоит
2. Немного беспокоит
3. Не очень беспокоит
4. Совсем не беспокоит
(9) Затрудняюсь ответить/нет мнения

Представьте себе тяжелые заболевания, которые могут возникнуть вследствие несчастного случая, рак, сердечный приступ и т.д.

25.2. Насколько Вас лично беспокоит то, что Вы, возможно, не сможете платить за медицинскую помощь, если Вы или член Вашей семьи тяжело заболеет в будущем? Вас это: */ЗАЧИТАЙТЕ/*

1. Очень беспокоит
2. Немного беспокоит
3. Не очень беспокоит
4. Совсем не беспокоит
(9) Затрудняюсь ответить/нет мнения

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26. Скажите, пожалуйста, приходилось ли Вам в последнее время читать или слышать что-либо о новом законе об обязательном медицинском страховании в России?

(1) Да -->*К ВОПРОСАМ 27-28*
(2) Нет -->*К ВОПРОСУ 29*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 29*

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27. Известно ли Вам о положении нового закона, где предоставляется возможность добровольного страхования, которое позволит наряду с обязательной основной медицинской помощью получить дополнительную медицинскую помощь на средства от добровольных взносов? */НЕ ЧИТАТЬ/*

(1) Да, известно
(2) Нет, не известно
(9) Затрудняюсь ответить/нет мнения

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28. Вспомните, пожалуйста, о том, что Вы видели, читали или слышали о новом законе об обязательном медицинском страховании и скажите мне, считаете ли Вы, что новая правительственная программа по медицинскому страхованию улучшит медицинское обслуживание, которое Вы получаете или ухудшит его?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы думаете, что новая программа существенно улучшит/ухудшит медицинское обслуживание или лишь несколько улучшит/ухудшит?

(1) Существенно улучшит
(2) Несколько улучшит
(3) Несколько ухудшит
(4) Существенно ухудшит
(5) Ничего не изменится
(9) Затрудняюсь ответить/нет мнения

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29. В настоящее время в России ведется кампания по пропаганде здорового образа жизни, например, проводятся образовательные программы о вреде курения, употребления алкоголя в больших количествах и так далее. Скажите, пожалуйста, приходилось ли Вам в последнее время видеть, читать или слышать что-либо из образовательных программ о защите здоровья по телевизору, радио, из газет или из любых других источников?

(1) Да -->*К ВОПРОСАМ 30*
(2) Нет -->*К ВОПРОСУ 31*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 31*

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30. Скажите, пожалуйста, послужили ли образовательные программы по охране здоровья, которые Вы смотрели, читали или о которых Вы слышали, причиной изменений в Ваших привычках или побудили Вас делать что-либо по другому, чем раньше или нет?

(1) Да, изменило
(2) Нет, не изменило
(9) Затрудняюсь ответить/нет мнения

СПРОСИТЕ ВСЕХ

31. Теперь мне хотелось бы зачитать Вам различные точки зрения на поддержание здоровья. Пожалуйста, скажите мне, какая из точек зрения, которые я Вам приведу, ближе к Вашей собственной? */ЗАЧИТАЙТЕ ТОЧКИ ЗРЕНИЯ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

Некоторые люди говорят, что для того, чтобы предотвратить заболевание, лучше хотя бы раз в год ходить на осмотр к врачу, делать физические упражнения и правильно питаться.

Другие считают, что к врачу нужно ходить только тогда, когда заболеешь. Кроме этого, занятие физическими упражнениями и борьба с вредными привычками только осложняют жизнь, а не приносят реальной пользы и в любом случае не помогают.

Какая из этих точек зрения ближе к Вашей собственной? */НЕ ЧИТАТЬ/*

(1) Нужно предотвращать заболевание
(2) Только создают проблемы, но не помогают
(3) Оба утверждения в равной степени близки
(9) Затрудняюсь ответить/нет мнения

Еще несколько вопросов о медицинской помощи в России.

32. Случалось ли Вам в недавнее время отказаться от медицинской помощи для Вас или для другого члена Вашей семьи из-за того, что Вы были не уверены в качестве обслуживания, которое Вы можете получить, хотя раньше Вы, возможно, и обратились бы за помощью?

(1) Да
(2) Нет
(9) Затрудняюсь ответить/нет мнения

Вспомните, пожалуйста, случалось ли когда-либо за последние два года, что Вы или кто-либо из Вашей семьи был вынужден ждать значительное время, чтобы записаться на прием к врачу или получить какой-либо другой вид медицинской помощи.

33. Какое максимальное время Вам приходилось ждать от записи до приема - день, от двух до шести дней, неделю, две недели, месяц или более одного месяца?

(1) Один день
(2) 2-5 дней
(3) Одну неделю
(4) Две недели
(5) Один месяц
(6) Более одного месяца
(7) Никогда не приходилось долго ждать
(8) Не пользовался медицинской помощью в последние два года
(9) Затрудняюсь ответить/нет мнения

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33А. За последние два года, какое максимальное время Вам приходилось ждать в очереди, когда Вы уже пришли на прием - около получаса, около часа, от одного до двух часов, от трех до пяти часов или более пяти часов? */НЕ ЧИТАТЬ/*

(1) Около получаса
(2) Около часа
(3) От 1 до 2 часов
(4) От 3 до 5 часов
(5) Более пяти часов
(7) Никогда не приходилось долго ждать
(8) Не пользовался медицинской помощью в последние два года
(9) Затрудняюсь ответить/нет мнения

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34. Как Вы, возможно, знаете, система медицинского обслуживания в России в настоящее время находится в состоянии изменений и переживает больше трудности. Я зачитаю Вам список трудностей и проблем, с которыми сталкивается наша медицина, а Вы скажите мне, по Вашему мнению, над решением какой одной проблемы здравоохранения руководители нашей страны должны работать в первую очередь? *(ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА. ВОЗМОЖЕН ОДИН ВЫБОР)*

1. Прививки маленьким детям
2. Улучшение работы предприятий по очистке воды
3. Уменьшение загрязнения окружающей среды
4. Обучение докторов и мед.сестер работе с наиболее современной техникой и ознакомление их с новейшими технологиями в области медицины
5. Обеспечение больниц и поликлиник необходимым оборудованием и лекарствами
6. Поддержание фармацевтических предприятий, выпускающих лекарства, медикаменты
7. Информирование и предупреждение населения о вреде курения и алкоголя

(8) Комбинация из перечисленного */НЕ ЧИТАТЬ/*
(9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

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35. Теперь мне хотелось бы зачитать Вам список проблем, которые волнуют людей в России в настоящее время. Пожалуйста, послушайте список и скажите мне, какая одна проблема больше всего беспокоит в настоящее время лично Вас? *(ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА. ВОЗМОЖЕН ОДИН ВЫБОР.)*

1. Врачи недостаточно квалифицированы и могут сделать ошибку в лечении меня или членов моей семьи
2. Правительство может урезать финансирование системы здравоохранения и я буду вынужден платить за медицинское обслуживание больше, чем я в состоянии платить
3. Мне потребуется срочная медицинская помощь, а в больнице не окажется анестезии или необходимого оборудования
4. Моим детям потребуется лекарство или прививка, а лекарства не окажется в продаже
5. У меня обнаружится заболевание, которое могло бы быть предотвращено, если бы я был достаточно информирован о нем

(8) Комбинация из перечисленного */НЕ ЧИТАТЬ/*
(9) Затрудняюсь ответить/нет мнения */НЕ ЧИТАТЬ/*

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36. Теперь я зачитаю Вам несколько возможных целей реформирования нашей системы здравоохранения. Скажите мне, пожалуйста, какую одну цель Вы в наибольшей степени предпочли бы видеть одной из целей реформирования системы здравоохранения нашей страны? */ЗАЧИТАЙТЕ ЦЕЛИ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

Сохранить бесплатное медицинского обслуживание для всех россиян

или

Гарантировать, что качество медицинского обслуживания, которое получаете Вы и Ваша семья, наилучшее из всего возможного, даже если за него нужно платить

(1) Бесплатное медицинское обслуживание
(2) Качество медицинского обслуживания
(9) Затрудняюсь ответить/нет мнения

Еще один вопрос о целях реформирования нашей системы здравоохранения. */ЗАЧИТАЙТЕ ЦЕЛИ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

37. Что Вы в большей степени предпочли бы видеть целью реформирования системы здравоохранения нашей страны?

Сделать некоторые виды медицинского обслуживания платными, чтобы улучшить качество основного медицинского обслуживания

или

Гарантировить, что все россияне будут иметь доступ ко всем видам медицинского обслуживания, даже если качество обслуживания останется таким же, как сейчас

(1) Некоторые виды платные, но общее обслуживание лучшего качества
(2) Бесплатное обслуживание для всех, даже если качество не улучшится
(9) Затрудняюсь ответить/нет мнения

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38. Теперь я зачитаю Вам утверждения, с которыми некоторые люди соглашаются, а некоторые нет. Пожалуйста, скажите мне, Вы лично согласны или не согласны со следующим утверждением?

"Система здравоохранения, которую мы имеем сегодня в России, безусловно, хорошая система и существующие сегодня проблемы лишь временное явление".

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы полностью согласны/не согласны с этим утверждением или лишь частично согласны/не согласны с ним?

(1) Совершенно согласны
(2) Частично согласны
(3) Частично не согласны
(4) Совершенно не согласны
(9) Затрудняюсь ответить/нет мнения

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39. Я приведу Вам две различные точки зрения, а Вы скажите мне, какая из них ближе к Вашей собственной точке зрения? */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

Некоторые говорят, что люди никогда не должны платить за основную медицинскую помощь, то есть за медицинскую помощь, которая жизненно необходима людям, а должны платить только за особые услуги или особый комфорт, такой, например, как отдельная палата в больнице и т.д.

Другие утверждают, что платное обслуживание пациентов - это единственный способ создать конкуренцию среди врачей, заставить их улучшить качество обслуживания и удержать цены на приемлемом уровне

К какому из этих утверждений ближе Ваша собственная точка зрения?

(1) Не должны платить за услуги
(2) Должны платить за услуги
(3) Близок и к тому, и к другому в равной степени
(9) Затрудняюсь ответить/нет мнения

554

40. Если бы цена Вас не волновала и Вы могли бы обратиться за медицинской помощью в любое медицинское учреждение в любой точке страны, куда из перечисленного Вы бы наиболее вероятно обратились - в: */ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/* местную поликлинику, местному частному врачу, поликлинику в другом городе, частному врачу в другом городе или куда-нибудь еще? */НЕ ЧИТАТЬ/*

(1) Местную поликлинику
(2) Местному частному врачу
(3) Поликлинику в другом городе
(4) Частному врачу в другом городе
(8) Другое */КУДА ИМЕННО/* _____
(9) Затрудняюсь ответить/нет мнения

Теперь мне бы хотелось зачитать Вам список некоторых медицинских услуг, которые могут рассматриваться как "базовое медицинское обслуживание" и за которое государство однажды, возможно, не сможет больше платить. Пожалуйста, скажите мне по поводу каждой из этих услуг, согласились бы Вы платить дополнительно за то, чтобы получить каждую из этих медицинских услуг или нет. Первая из них... */ЗАЧИТАЙТЕ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

		Согласился бы	Не согласился	Затрудняюсь ответить
41.	Психиатрическое лечение, терапия	1	2	(9)
42.	Контрацепция, планирование семьи	1	2	(9)
43.	Лечение алкоголизма	1	2	(9)
44.	Профилактическое обследование	1	2	(9)
45.	Лечение детей	1	2	(9)
46.	Обследование зрения, подбор очков	1	2	(9)

Сейчас в стране обсуждается вопрос о создании таких больниц и поликлиник, которые будут находиться не под руководством государства, а будут организованы так называемыми "доверительными обществами". Это значит, что в то время как государство следит за поддержанием определенного уровня медицинского обслуживания, управление медицинским учреждением находится в руках церкви, благотворительного общества, общественной организации или другой группы частных лиц, которые не получают доход от этой организации.

47. Согласились бы Вы посещать в больницу или поликлинику, находящую под управлением "доверительного общества", а не государства или не согласились бы?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы совершенно точно так считаете или лишь отчасти?

(1) Совершенно точно согласился бы
(2) Наверное, согласился бы
(3) Наверное, не согласился бы
(4) Совершенно точно не согласился бы
(9) Затрудняюсь ответить/нет мнения

Если бы больница или поликлиника находилась в руках группы частных лиц, например, группы врачей, которые там работали, и эти люди могли бы получить доход от деятельности своего медицинского учреждения, если дела идут хорошо

48. Согласились бы Вы посещать больницу или поликлинику, находящую под управлением группы частных лиц или частной организации, а не государства или не согласились бы?

КОГДА ОТВЕТ ДАН, СПРОСИТЕ: Вы совершенно точно так считаете или лишь отчасти?

(1) Совершенно точно согласился бы -->*К ВОПРОСУ 50*
(2) Наверное, согласился бы -->*К ВОПРОСУ 50*
(3) Наверное, не согласился бы -->*К ВОПРОСУ 49*
(4) Совершенно точно не согласился бы -->*К ВОПРОСУ 49*
(9) Затрудняюсь ответить/нет мнения -->*К ВОПРОСУ 49*

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49. Какова одна наиболее важная причина, по которой Вы не пошли бы в поликлинику или больницу, находящуюся под управлением частных лиц или частной организации? *(ЗАПИШИТЕ ДОСЛОВНО ОТВЕТ РЕСПОНДЕНТА. ПОСТАРАЙТЕСЬ ПОЛУЧИТЬ КАК МОЖНО БОЛЕЕ КОНКРЕТНЫЙ ОТВЕТ)*

!_____!

!_____!

СПРОСИТЕ ВСЕХ

50. Мне хотелось бы зачитать Вам две точки зрения, а Вы, пожалуйста, скажите мне, какая из них ближе к Вашей собственной точке зрения? */ЗАЧИТАЙТЕ УТВЕРЖДЕНИЯ. ИЗМЕНЯЙТЕ ПОРЯДОК ЧТЕНИЯ НА ОБРАТНЫЙ ДЛЯ КАЖДОГО НОВОГО РЕСПОНДЕНТА/*

Некоторые люди говорят, что позволить частным лицам и организациям управлять российскими больницами и фармацевтическими предприятиями значит создать условия для того, что наши медицинские учреждения будут больше прислушиваться к нуждам пациентов, а здоровая конкуренция среди них позволит избежать неэффективности государственной системы здравоохранения

Другие люди говорят, что позволить частным лицам и организациям управлять медицинскими учреждениями будет значить создание системы здравоохранения, недоступной большинству россиян, и даст возможность людям, управляющим медициной, разбогатеть на наших несчастьях

К какому из этих утверждений ближе Ваша собственная точка зрения?

(1) Здоровая конкуренция улучшит медицинское обслуживание
(2) Сделает медицинскую помощь недоступной для большинства россиян
(3) Близок и к тому и к другому в равной степени
(9) Затрудняюсь ответить/нет мнения

Теперь я собираюсь зачитать Вам несколько утверждений, которые высказывают некоторые россияне по проблемам здравоохранения в нашей стране. Пожалуйста, послушайте эти утверждения и скажите мне по поводу каждого из них: Вы с ним полностью согласны, частично согласны, частично не согласны или полностью не согласны? *(ЗАЧИТАЙТЕ)*

	Полностью согласен	Частично согласен	Затрудняюсь ответить (НЕ ЧИТАТЬ)	Мне все равно (НЕ ЧИТАТЬ)	Частично не согласен	Полностью не согласен
51. Западные компании, которые продают лекарства и медицинское оборудование в России, просто используют нас в своих целях и должны быть изгнаны с российского рынка	1	2	(9)	(4)	5	6
52. Условия медицинского обслуживания в России должны быть едины для всех, даже если это будет означать снижение качества медицинского обслуживания в целом	1	2	(9)	(4)	5	6
53. Врачи настолько неквалифицированы, что я сам, вероятно, смог бы лучше лечить себя, чем они	1	2	(9)	(4)	5	6
54. Для того, чтобы врачи могли обеспечить пациентам необходимую им медицинскую помощь, нужно в первую очередь заменить устаревшее оборудование в больницах	1	2	(9)	(4)	5	6
55. Приватизация в любом случае плоха	1	2	(9)	(4)	5	6
56. Российские врачи в действительности лучше, чем западные, потому что они могут оказывать людям помощь даже без современных лекарств и дорогого оборудования	1	2	(9)	(4)	5	6

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57. За последние 12 месяцев пытались ли Вы делать что-либо из того что я перечислю, чтобы улучить или сохранить свое здоровье? */ЗАЧИТАЙТЕ. ВОЗМОЖНО НЕСКОЛЬКО ВЫБОРОВ/*

01. Стал меньше употреблять алкоголя или совсем перестал его употреблять
02. Бросил курить
03. Начал заниматься физическими упражнениями или увеличил количество своих занятий
04. Начал следить за качеством своего питания
05. Соблюдал диету, чтобы снизить вес
06. Регулярно измерял давление
07. Проверял уровень холестерина
08. Принимал витамины
09. Посещал семинары или лекции по охране здоровья
10. Читал медицинскую литературу

(98) Другое */ЧТО ИМЕННО/* _____

(99) Затрудняюсь ответить, отказ от ответа */НЕ ЧИТАТЬ/*

---

58. Скажите, пожалуйста, пострадало ли здоровье у Вас лично, кого-либо из членов Вашей семьи или близких знакомых за последние два года от загрязнения окружающей среды или Вы не знаете таких фактов?

(1) Да --> *К ВОПРОСУ 59*

(2) Нет --> *К ВОПРОСУ 60*

(9) Затрудняюсь ответить/нет мнения --> *К ВОПРОСУ 59*

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59. Скажите, пожалуйста, от какого рода загрязнений пострадали Вы или кто-либо из тех, кого Вы лично близко знаете? */ЗАЧИТАЙТЕ/*

1. От загрязнения воздуха
2. От химических продуктов, химического производства
3. Загрязнения воды
4. Радиации
5. Пестицидов в продуктах

(8) От чего-либо другого */ЧЕГО ИМЕННО/* _____

(9) Затрудняюсь ответить/нет мнения

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60. Считаете ли Вы местность, в которой Вы живете, очень вредной для Вашего здововья из-за сильного загрязнения окружающей среды, довольно вредной, не особенно вредной или не считаете ее вредной совсем? */НЕ ЧИТАТЬ/*

(1) Очень вредная

(2) Довольно вредная

(3) Не очень вредная

(4) Совершенно безвредная

(9) Затрудняюсь ответить/нет мнения

---

61. За последние два года как часто Вы находились в состоянии стресса или сильного нервного напряжения? */ЗАЧИТАЙТЕ/*

1. Практически ежедневно --> *К ВОПРОСУ 62*
2. Несколько раз в неделю --> *К ВОПРОСУ 62*
3. Несколько раз в месяц --> *К ВОПРОСУ 62*
4. Несколько раз в год --> *К ВОПРОСУ 62*
5. Никогда не испытывал стресса --> *К ВОПРОСУ 63*

(9) Затрудняюсь ответить --> *К ВОПРОСУ 63*

Здоровая Россия-2000

Презентация для U.S. AID

и

Российской Федерации

Июль 1994

ИССЛЕДОВАНИЕ СИСТЕМЫ ЗДРАВООХРАНЕНИЯ В РОССИИ
1 мая - 15 июня 1994

- Целевые группы - 10 групп в 4 городах

- Обзор средств массовой информации
  - 59 городов (IPCC)

- Опрос населения - потребителей мед. услуг
  - 44 города/ деревни, опрошено свыше 1500 чел.

- Опрос медицинских работников - 39 городов/дер.
  опрошено более 275 медицинских работников

- ИНТЕРВЬЮ (Медицинские учреждения/ Страхо-
  вые компании) 20 городов/138 интервью

ОПРОС ПОТРЕБИТЕЛЕЙ МЕДИЦИНСКИХ УСЛУГ

Места проведения опроса

Центр. и сев. Россия

Москва
Озеры
Рязань
Санкт-Петербург
Луга
Чичулино
Плашкино
Стремутка
Подосье
Ершово
Приозерье
Кормы
Торошино
Черниховизы
Большие Жезлы
Ежва
Зеленец
Вильгорт
Красногороск
Вологда

Южная Россия

Курск
Самара
Сызрань
Лайщево
Столбчий
Нармонка
Сокуры
Васуринская
Юзны
Елабуга
Изобильный
Новотроицкий
Тищенское
Красный Яр

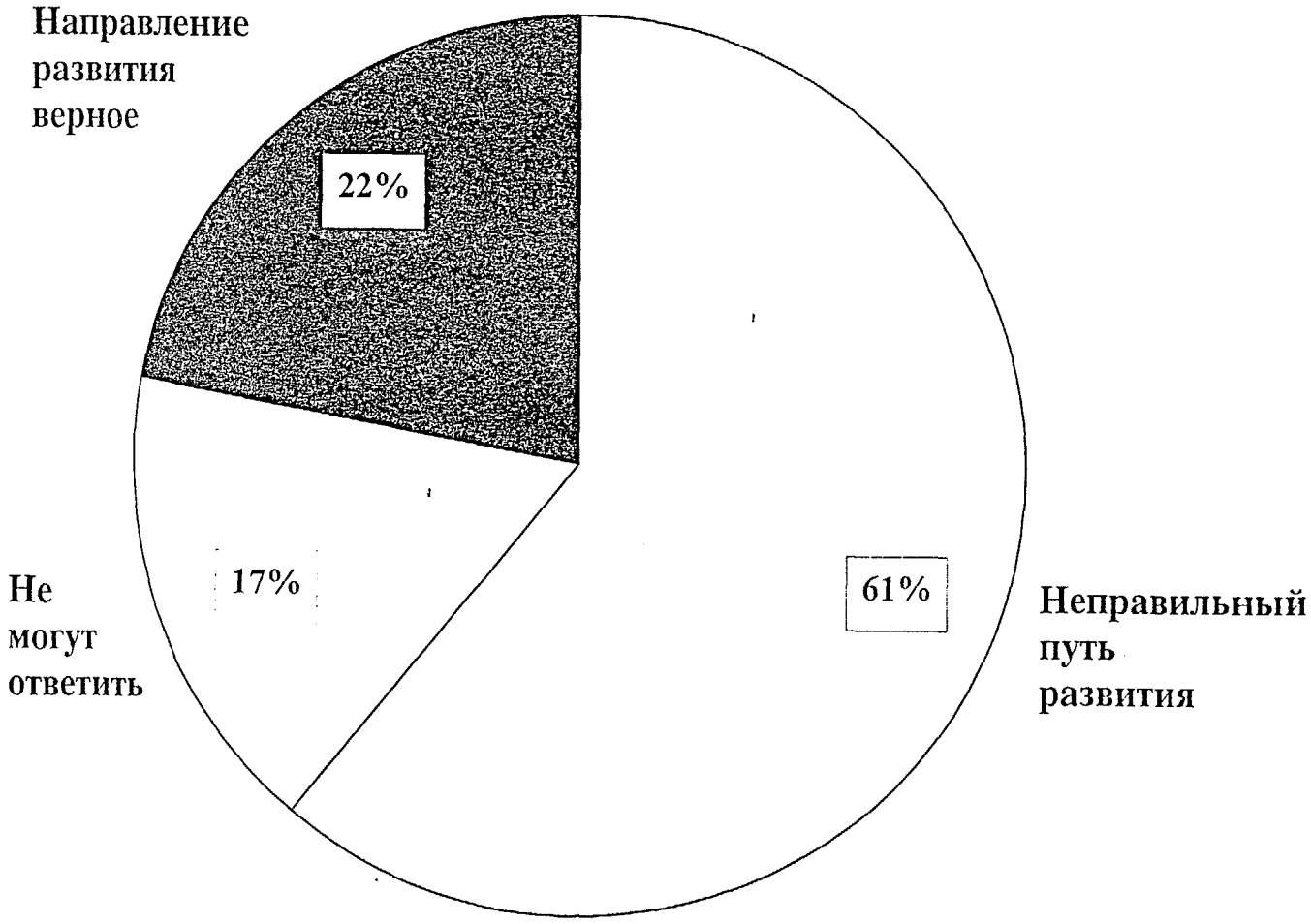
Урал/Сибирь

Октябрьское
Салават
Пермь
Кунгур
Невянск
Новосибирск
Завьялов
Октябрьский

Дальн. Восток

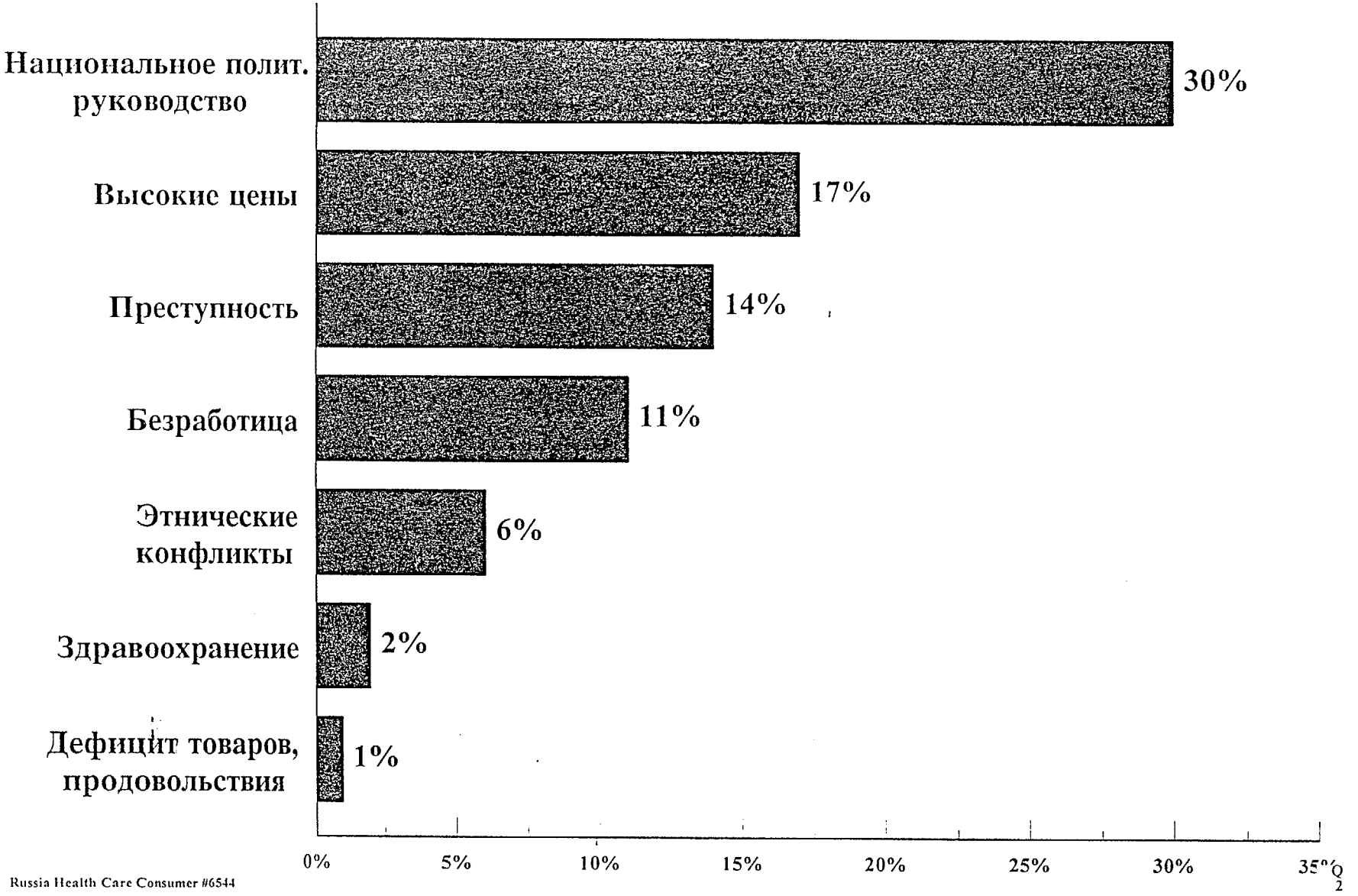
Назаров
Хабаровск

Расхождение мнений в России по поводу направления развития



Russia Health Care Consumer #6544

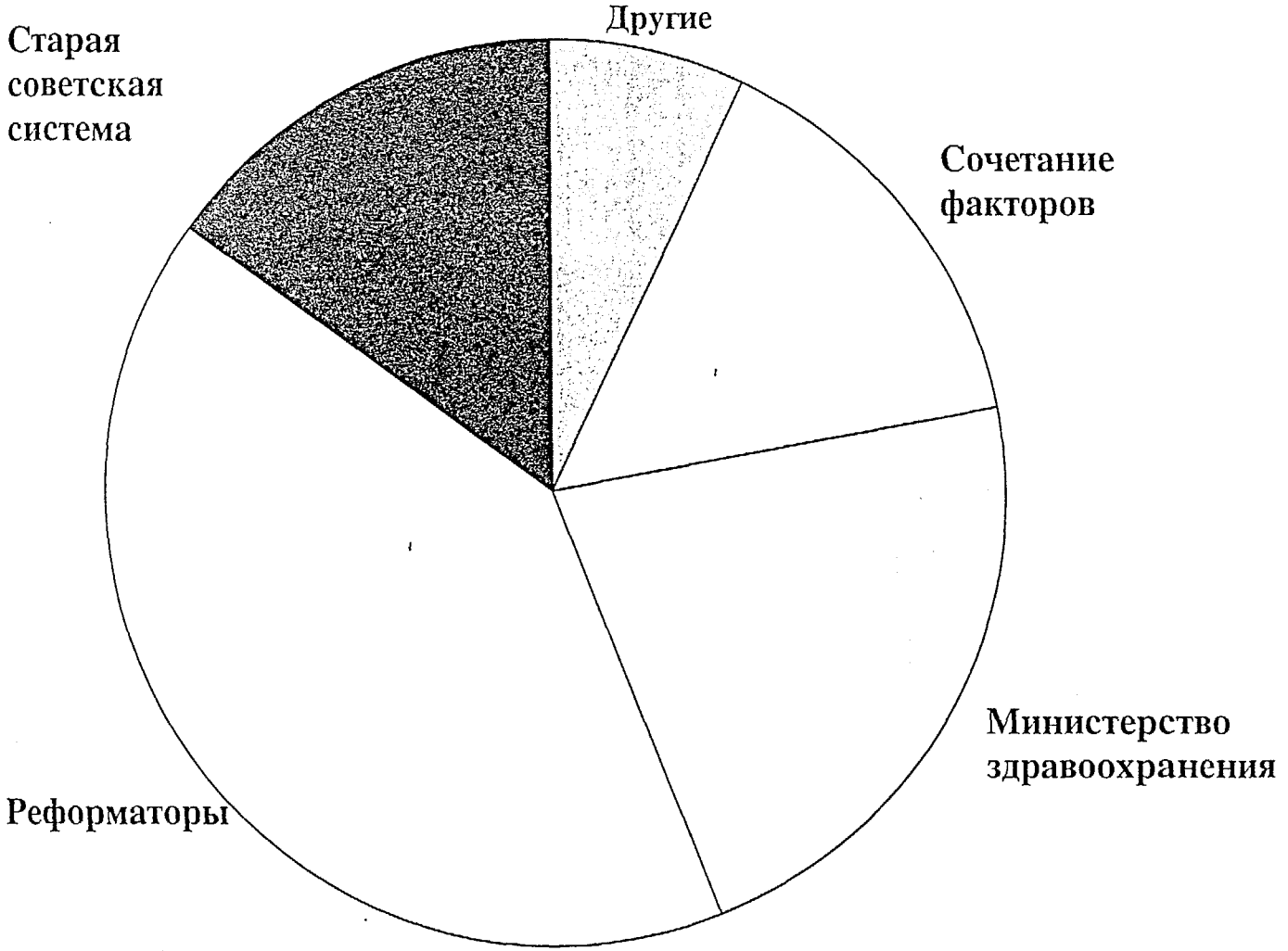
Наиболее важные проблемы в России



Russia Health Care Consumer #6544

562

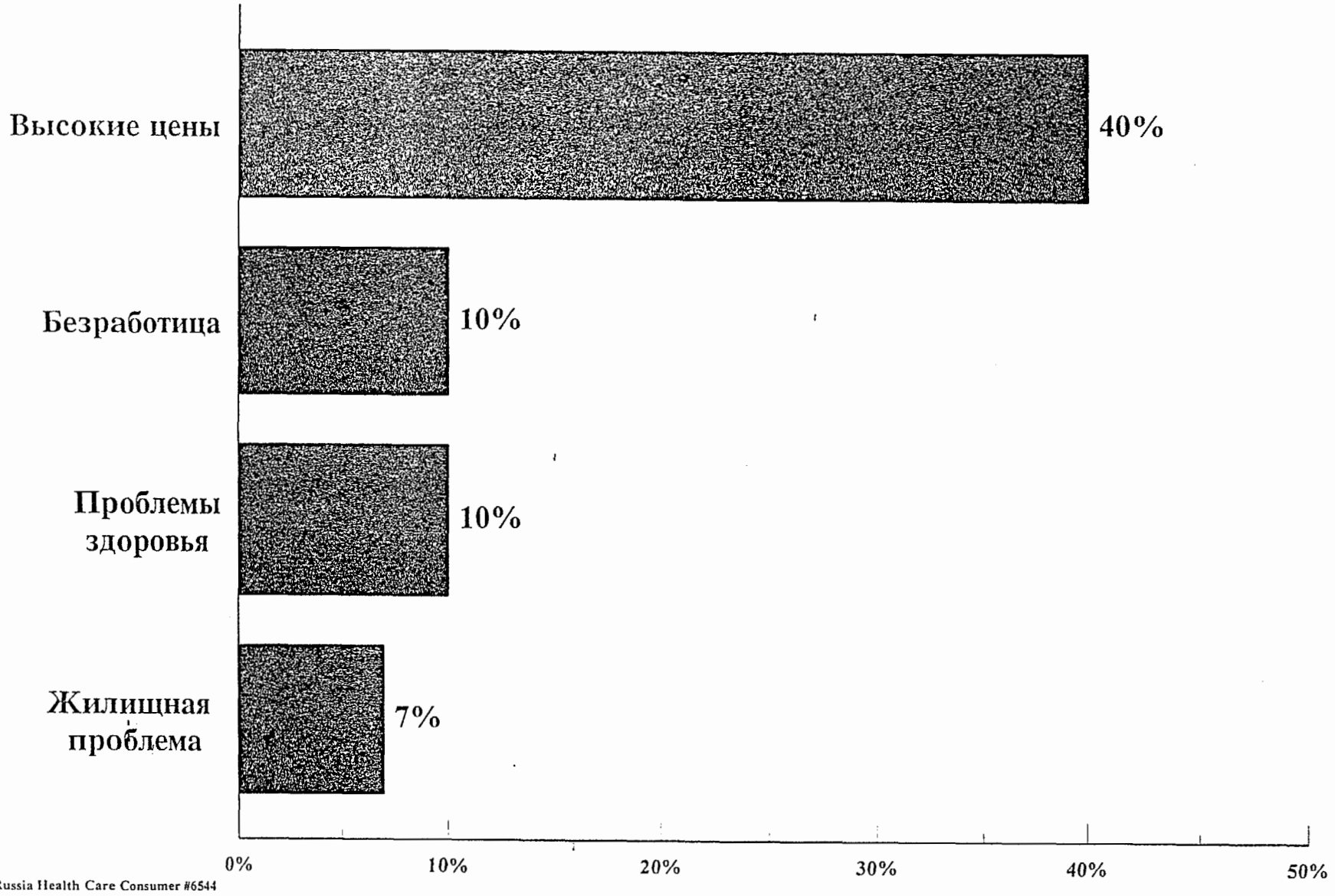
Кто, по Вашему мнению, в наибольшей степени в ответе за проблемы российского здравоохранения?
(Вопрос задан тем, кто не доволен системой здравоохранения.)



Russia Health Care Provider
#6559

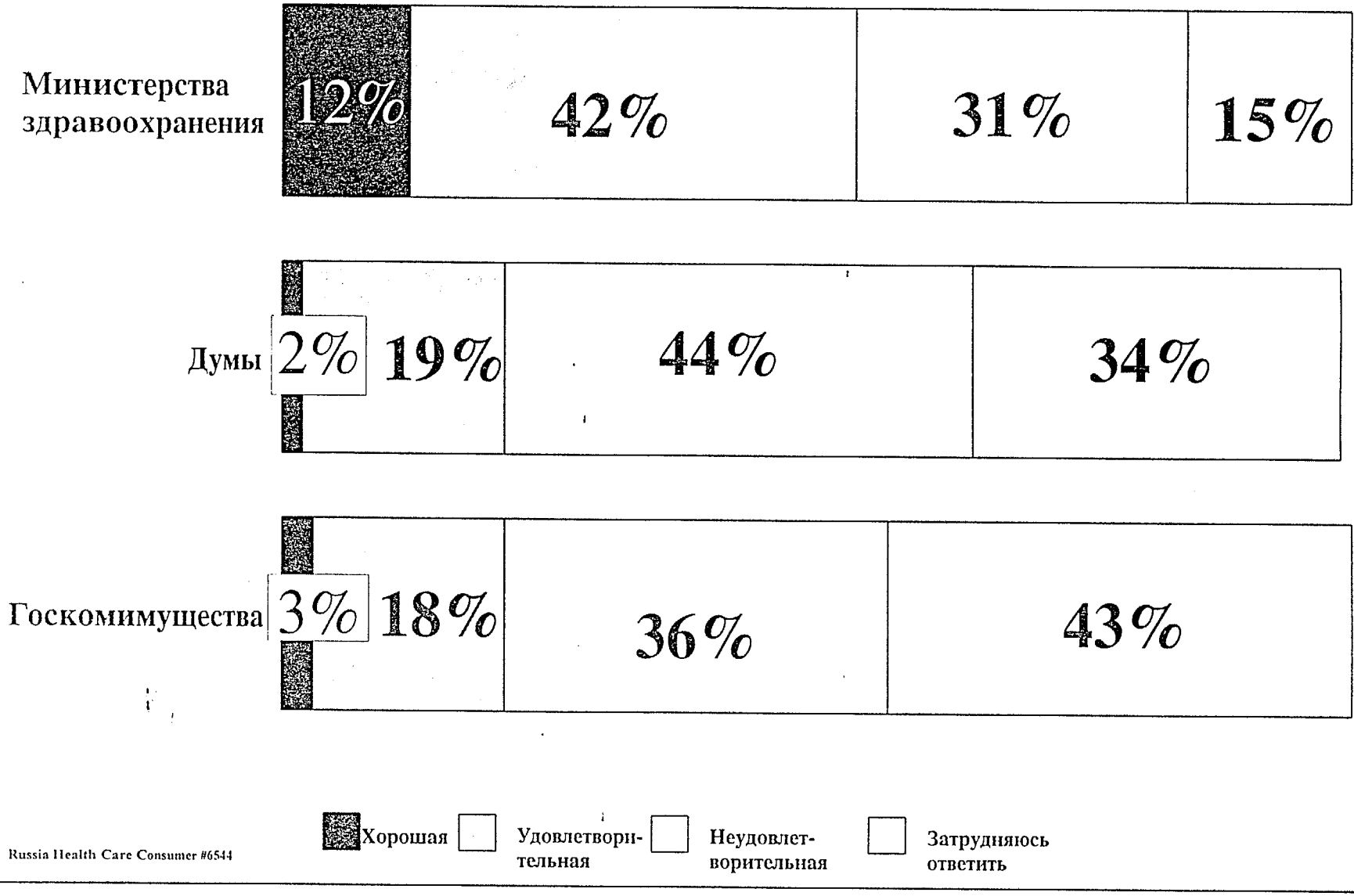
56

Какую проблему Вы считаете проблемой номер один для Вас лично?



Russia Health Care Consumer #6544

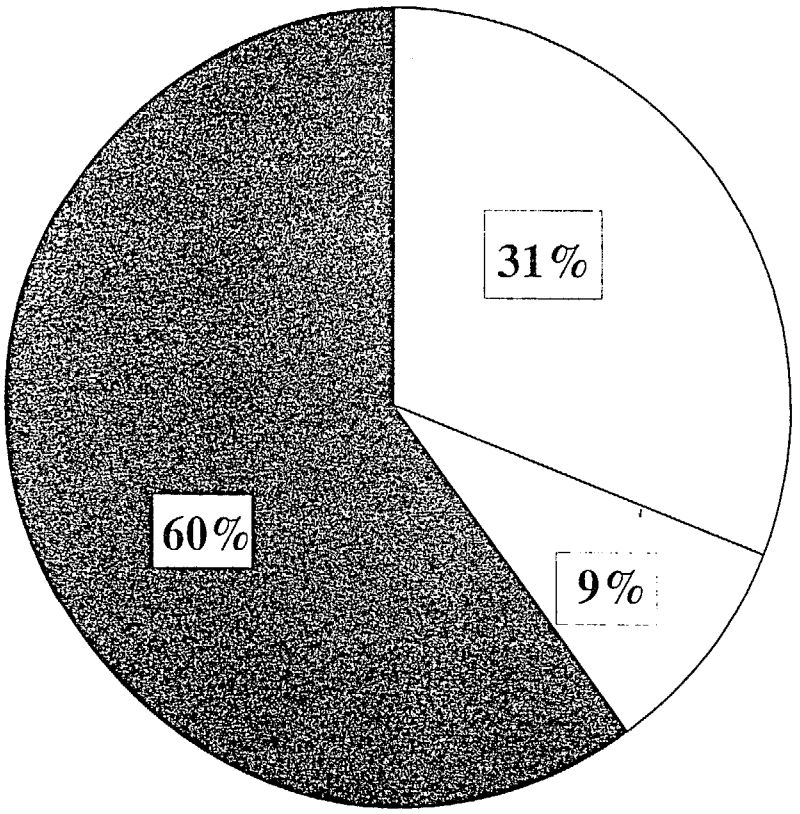
Оцените работу...



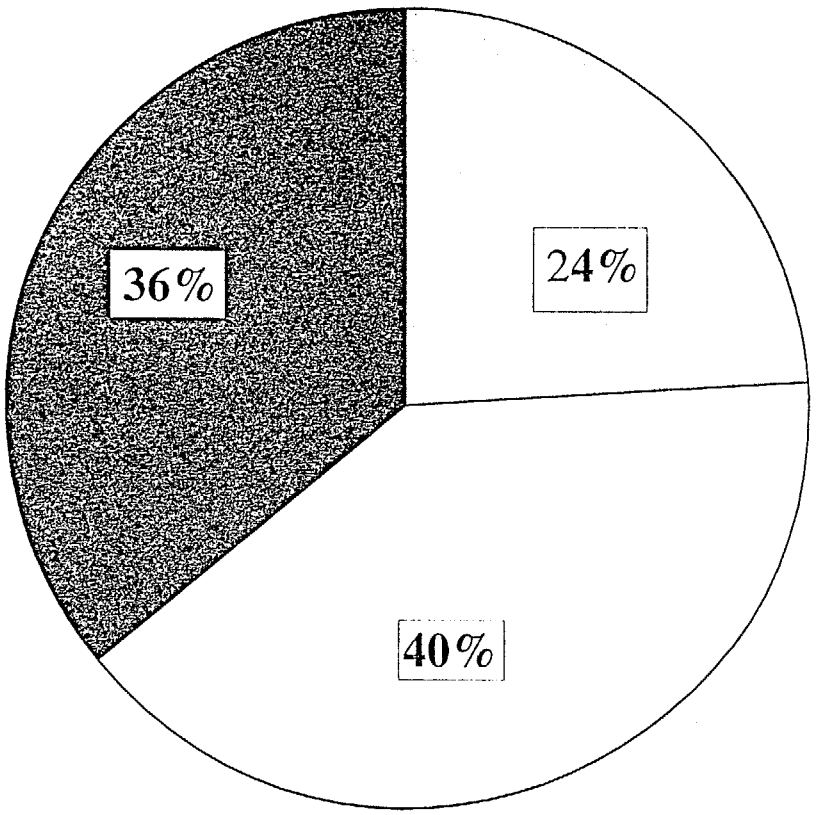
Russia Health Care Consumer #6544

565

Удовлетворены ли Вы...?



Местной поликлиникой



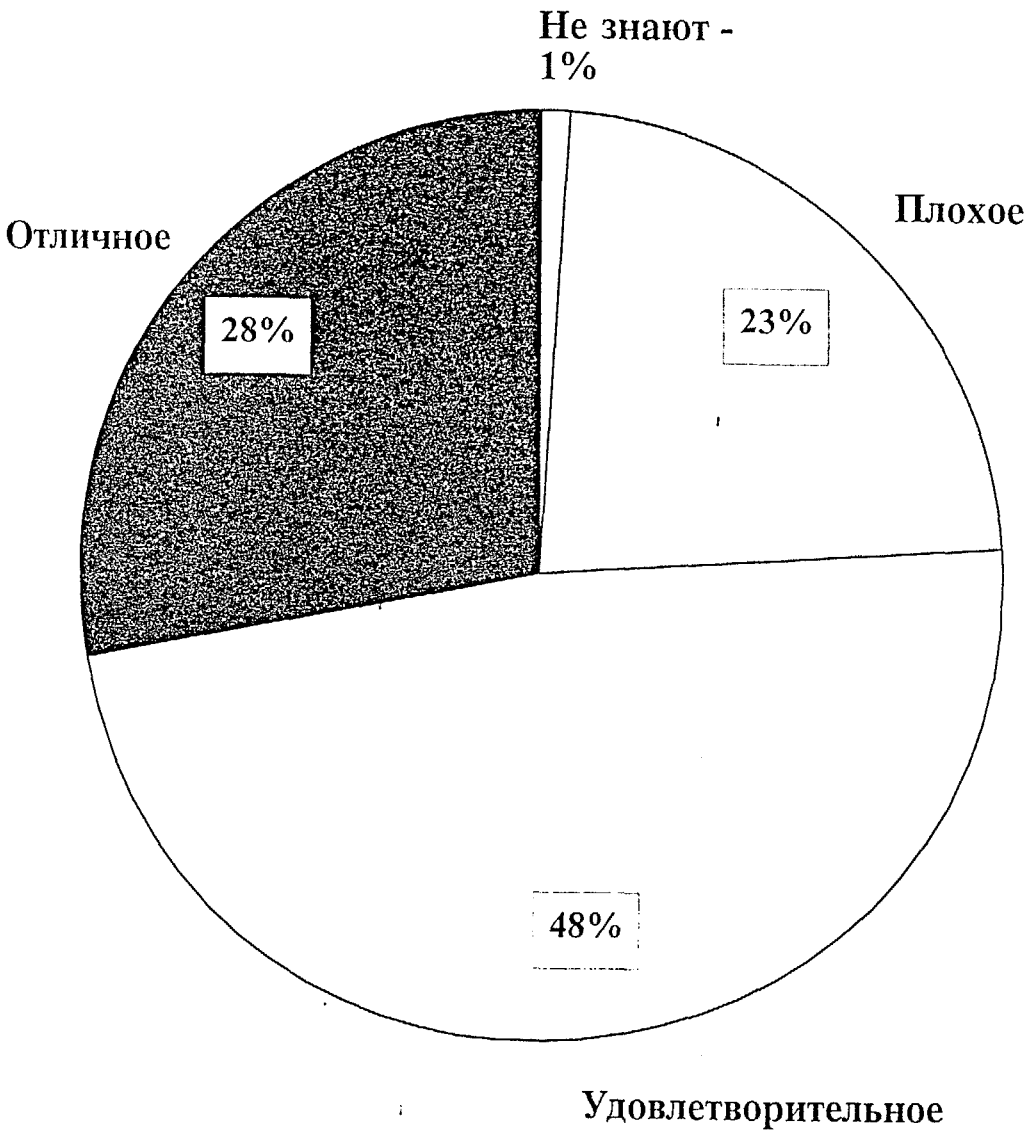
Областным Комитетом здравоохранения

Удовлетворены | Не знают | Не удовлетворены

Russia Health Care Consumer #6544

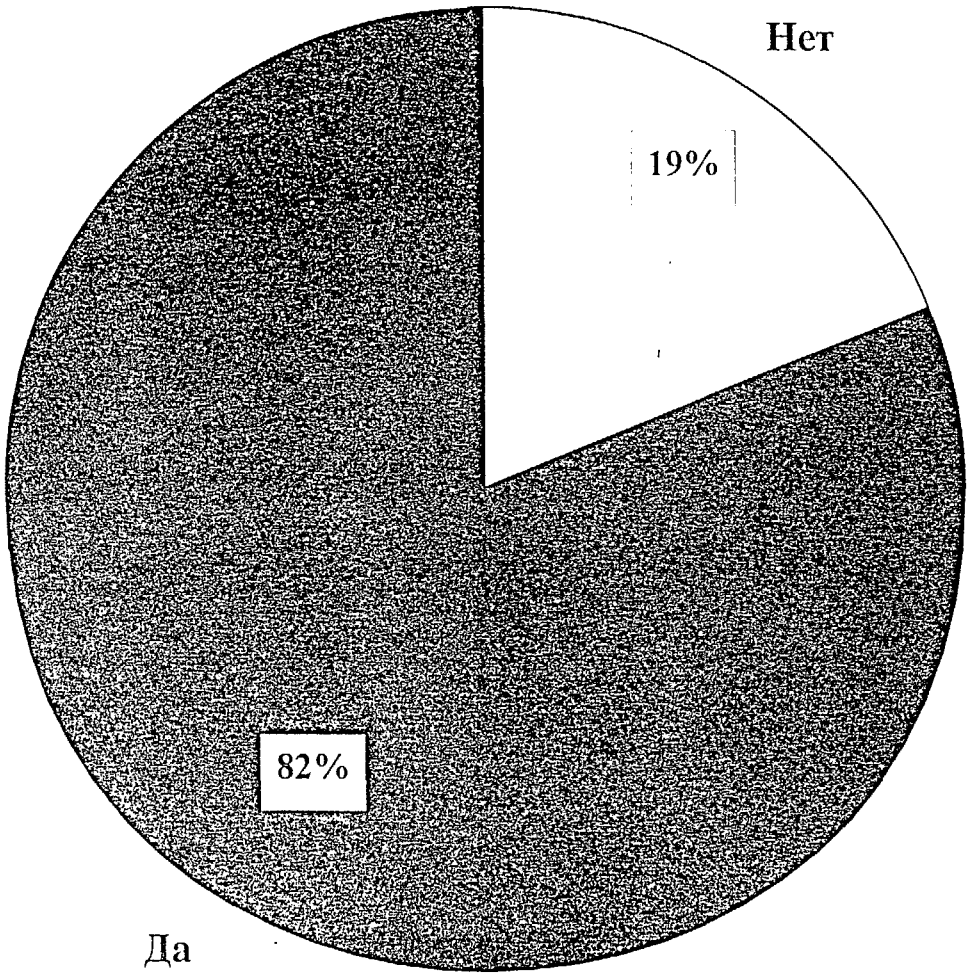
576

Как Вы оцениваете состояние Вашего здоровья?



Russia Health Care Consumer #6544

За последние два года приходилось ли Вам или членам Вашей семьи обращаться за бесплатной медицинской помощью?



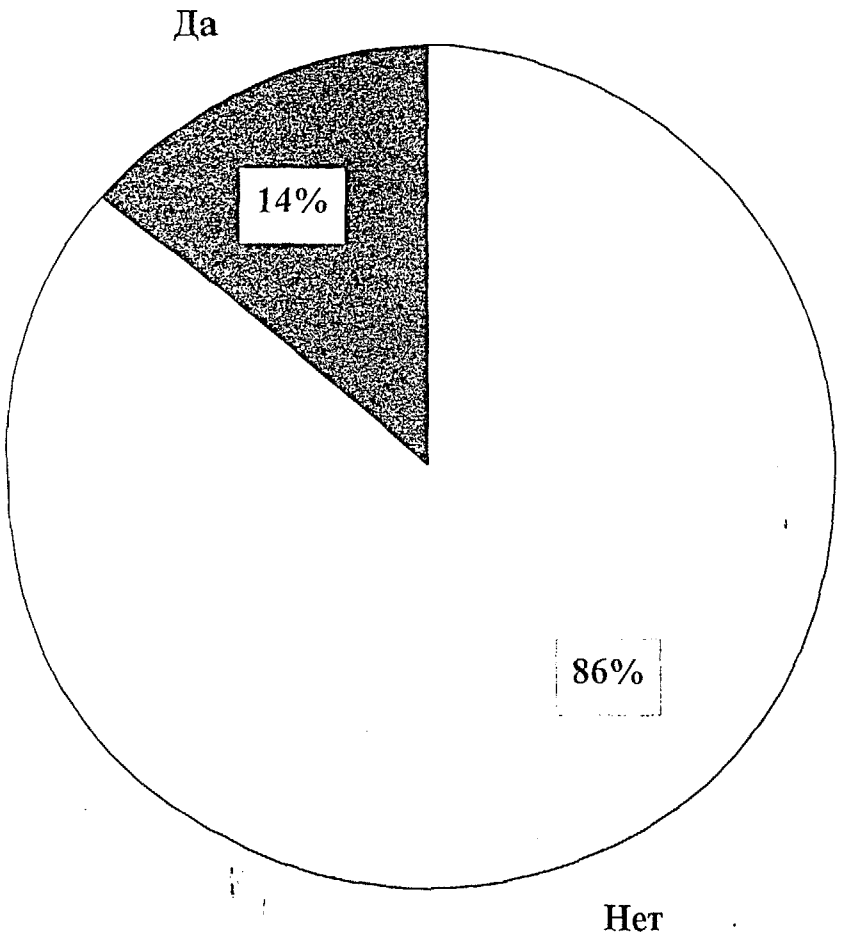
Russia Health Care Consumer #6544

Q
10

568

Приходилось ли Вам лично предлагать подарки или платить врачу или медсестрам за оказанные услуги?

(Для пользующихся бесплатной мед.помощью)

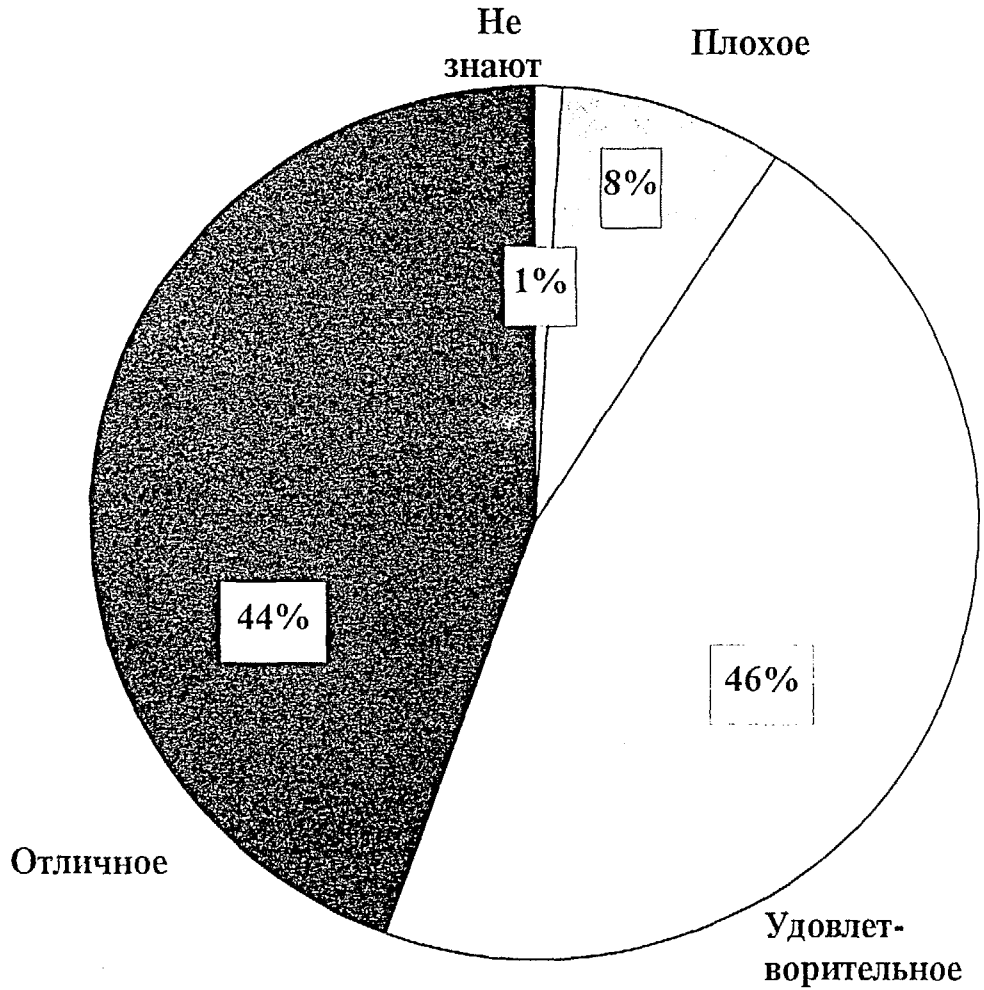


Russia Health Care Consumer
#6544

Q 13

Как Вы оцениваете качество мед.помощи?

(Для пользующихся бесплатной медицинской помощью)

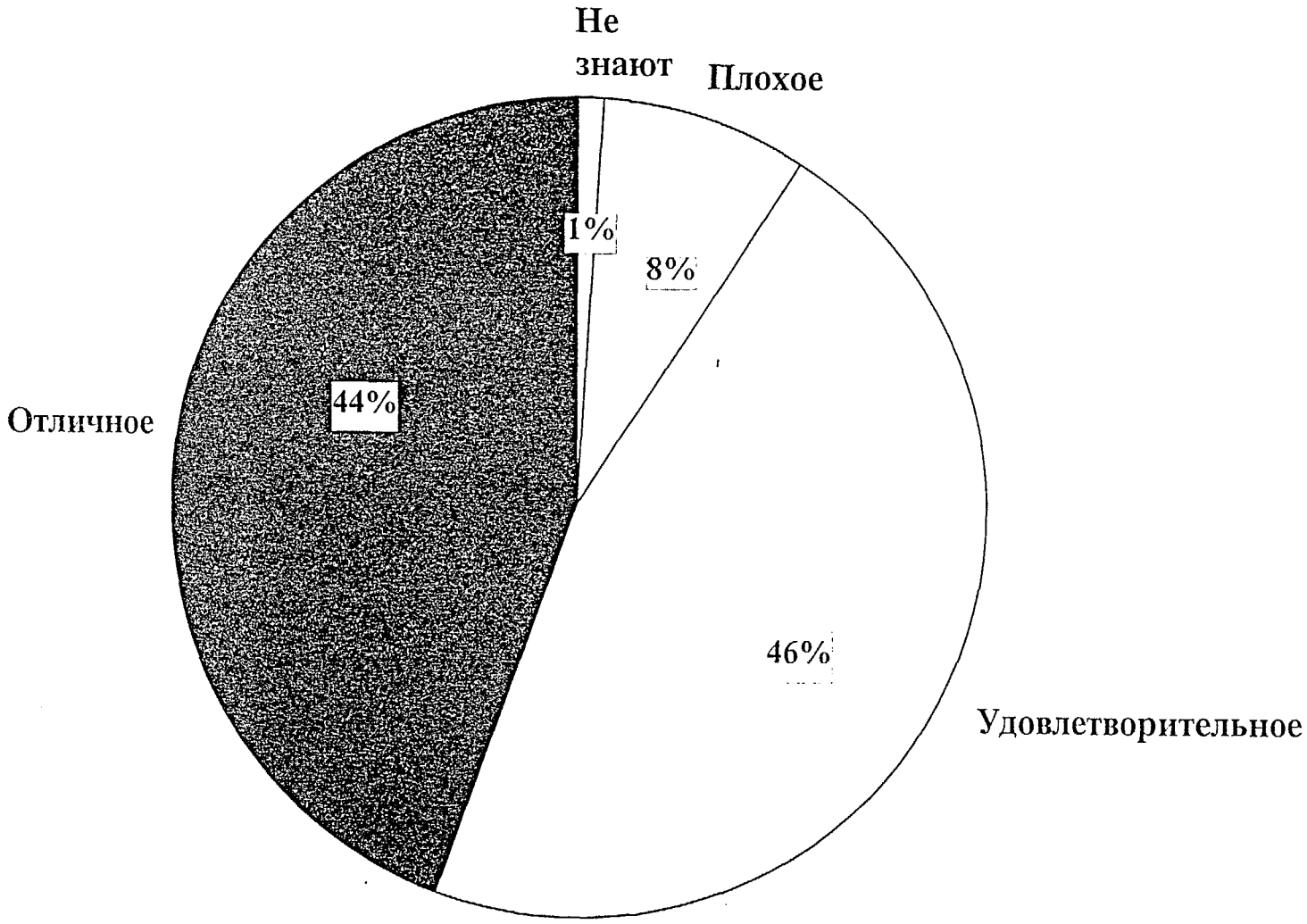


Russia Health Care Consumer
#6544

Q 14

569

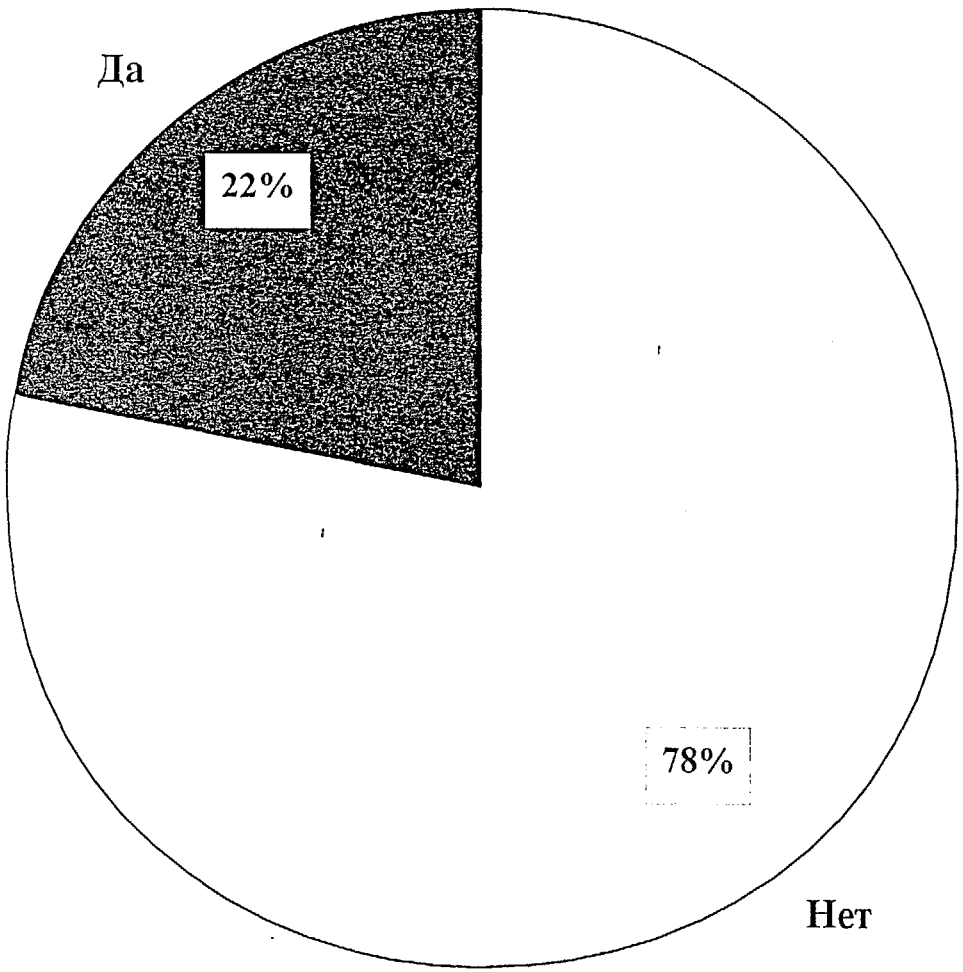
Оцените качество полученной Вами мед. помощи (Для пользующихся бесплатной мед. помощью)



Russia Health Care Consumer #6544

Q 14

Посещали ли Вы или члены Вашей семьи платного врача за последние два года?

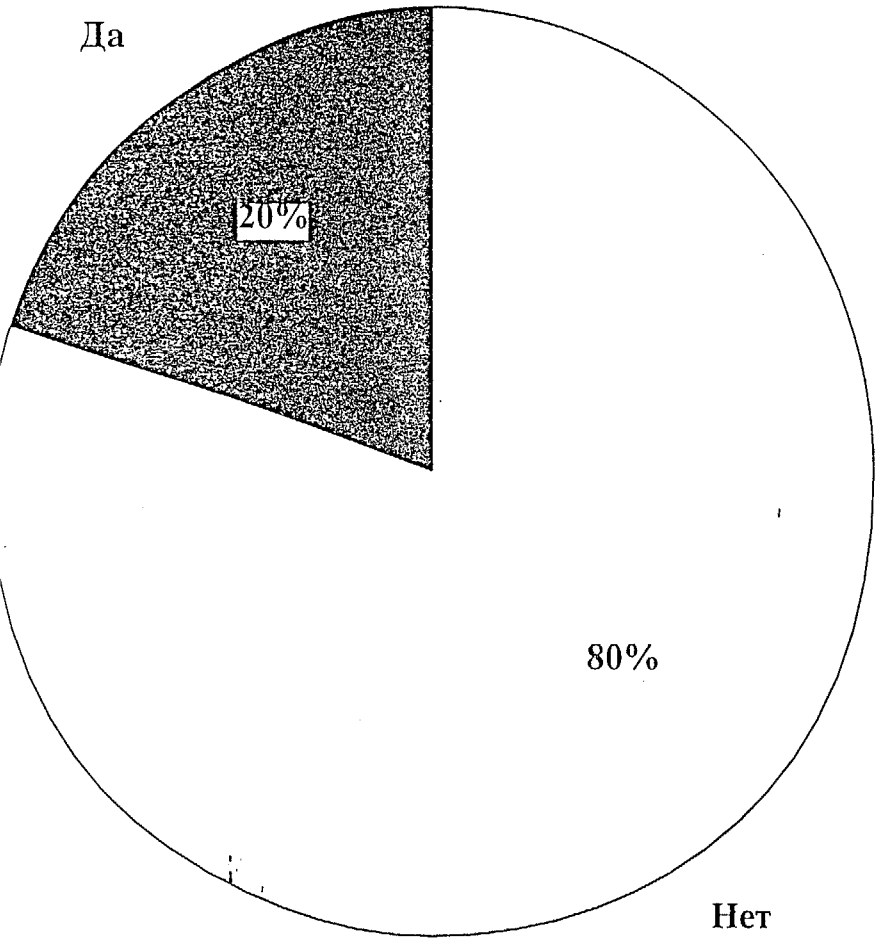


Russia Health Care Consumer #6544

Q
16

Приходилось ли Вам лично предлагать подарки или платить врачу или мед.сестрам за оказанные мед.услуги?

(Среди пользующихся платной мед. помощью)

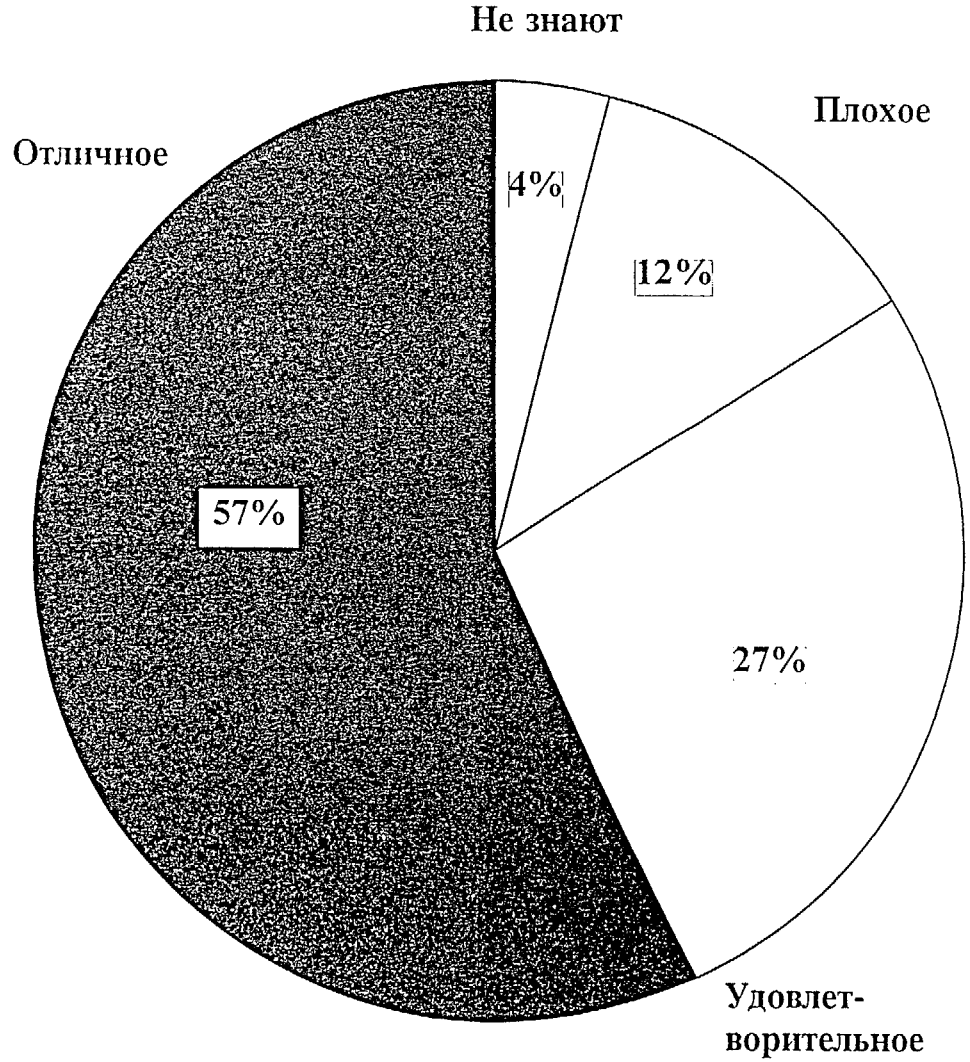


Russia Health Care Consumer
#6544

Q 17A

Как Вы оцениваете качество полученной платной мед. помощи ?

(Для пользующихся платной медицинской помощью)

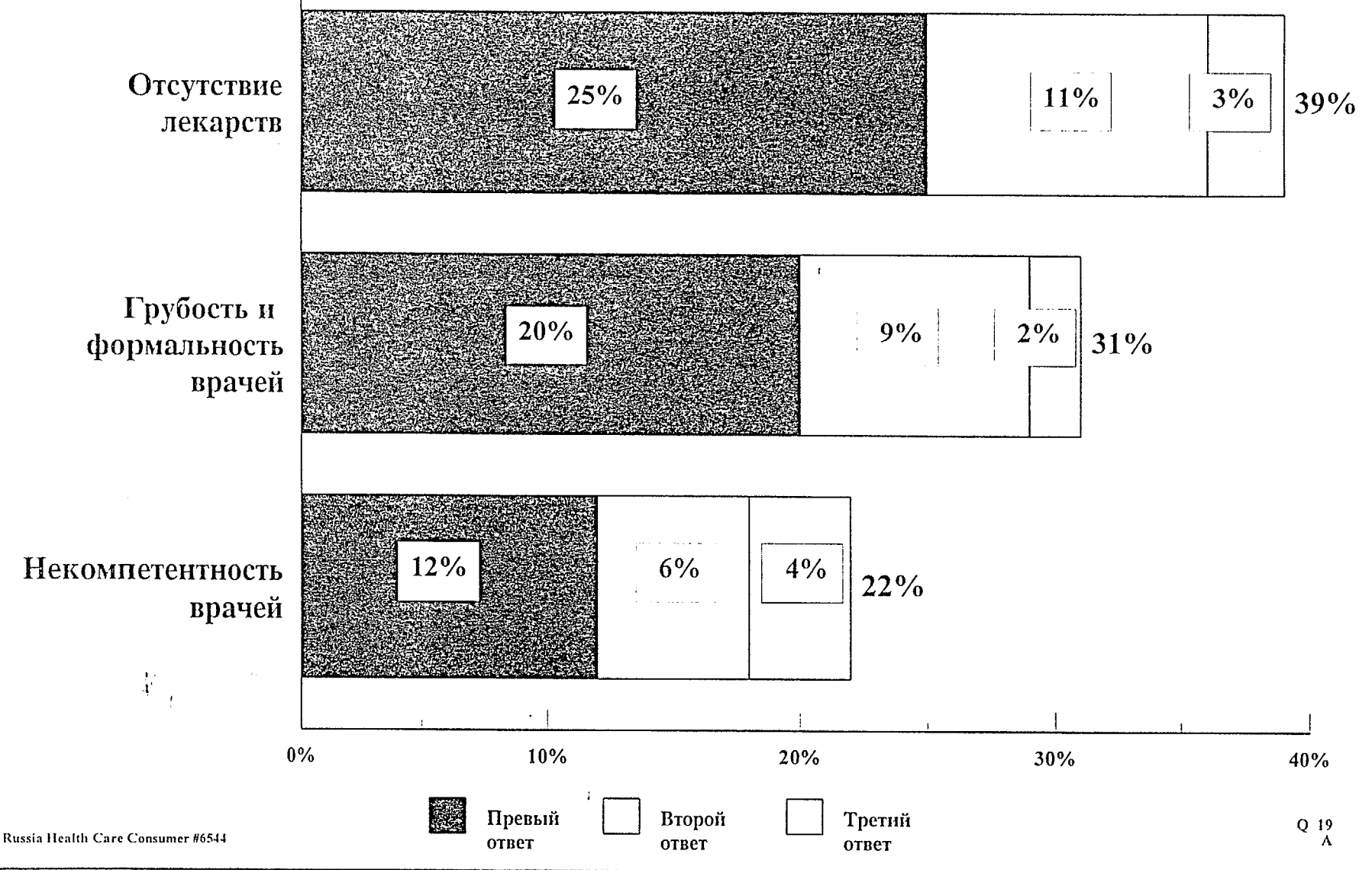


Russia Health Care Consumer
#6544

Q 18

Вопрос к потребителю: какова основная причина неудовлетворенности ?

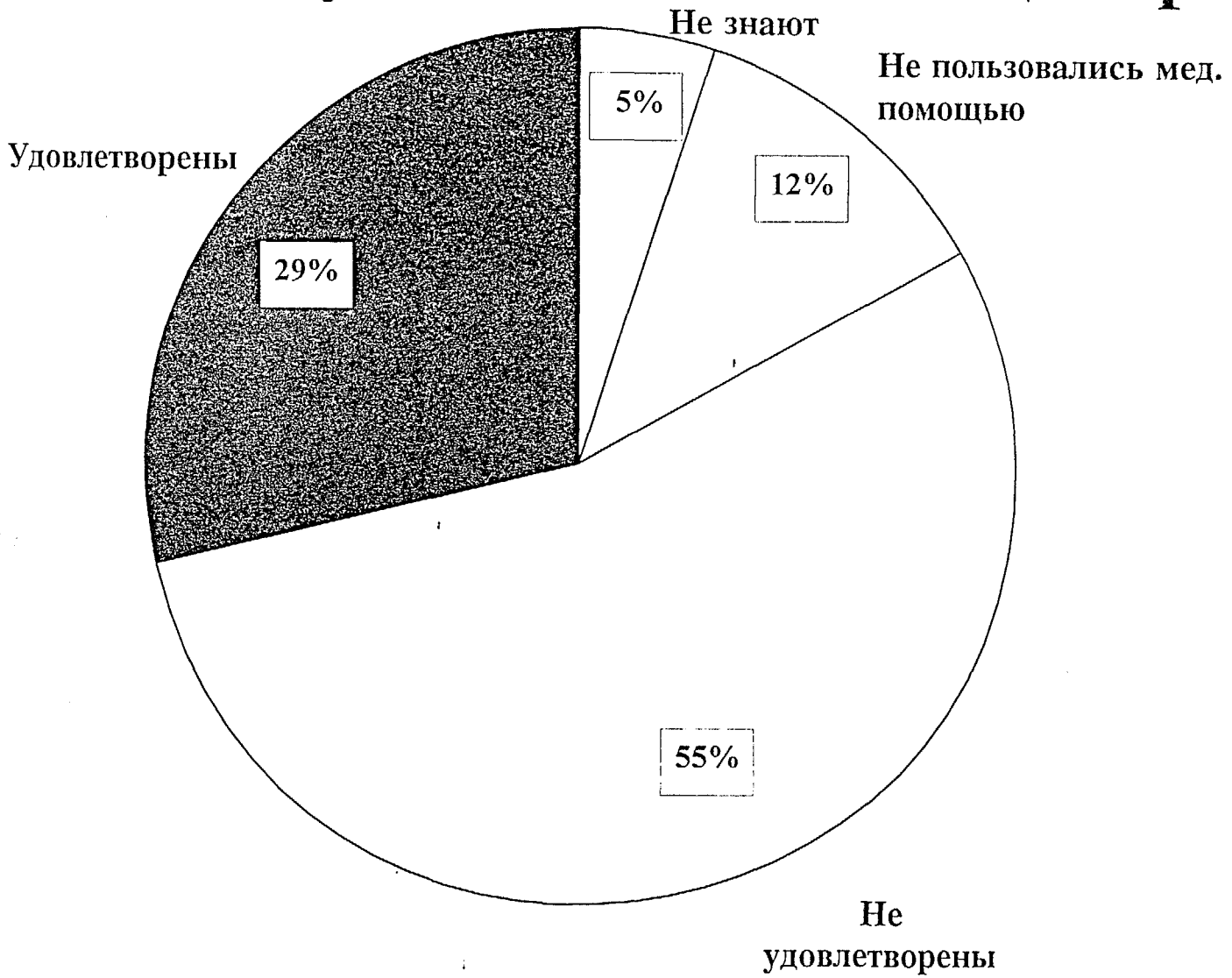
(среди неудовлетворенных мед. помощью)



Russia Health Care Consumer #6544

Q 19 A

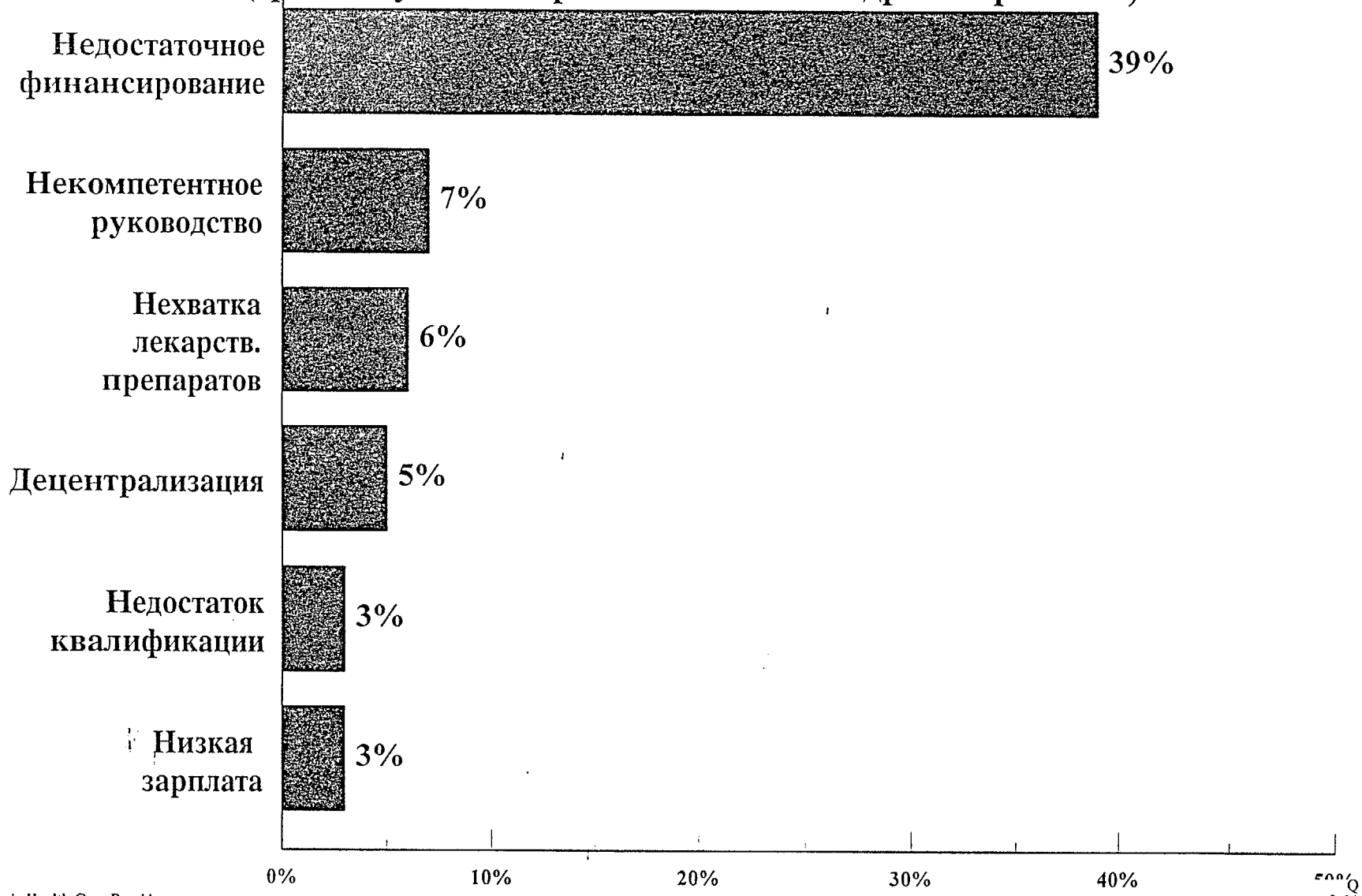
Вопрос к потребителю: насколько он удовлетворен мед. обслуживанием в настоящее время?



Russia Health Care Consumer #6544

Каковы основные причины Вашей неудовлетворенности системой здравоохранения?

(среди неудовлетворенных системой здравоохранения)



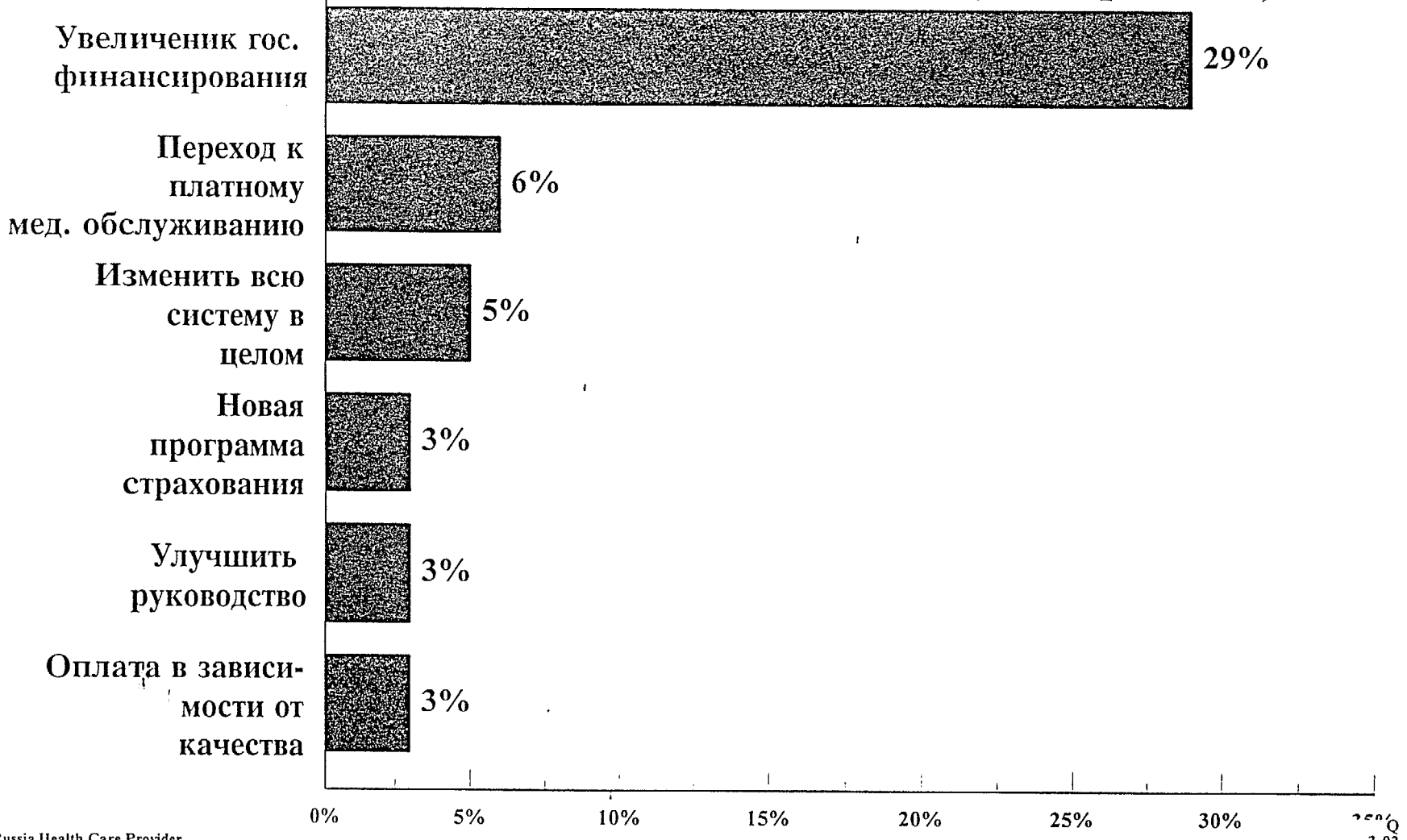
Russia Health Care Provider
#6559

3-01

Вопрос к медикам: что бы Вы сделали для улучшения системы здравоохранения?

Первое упоминание

(среди неудовлетворенных системой здравоохранения)

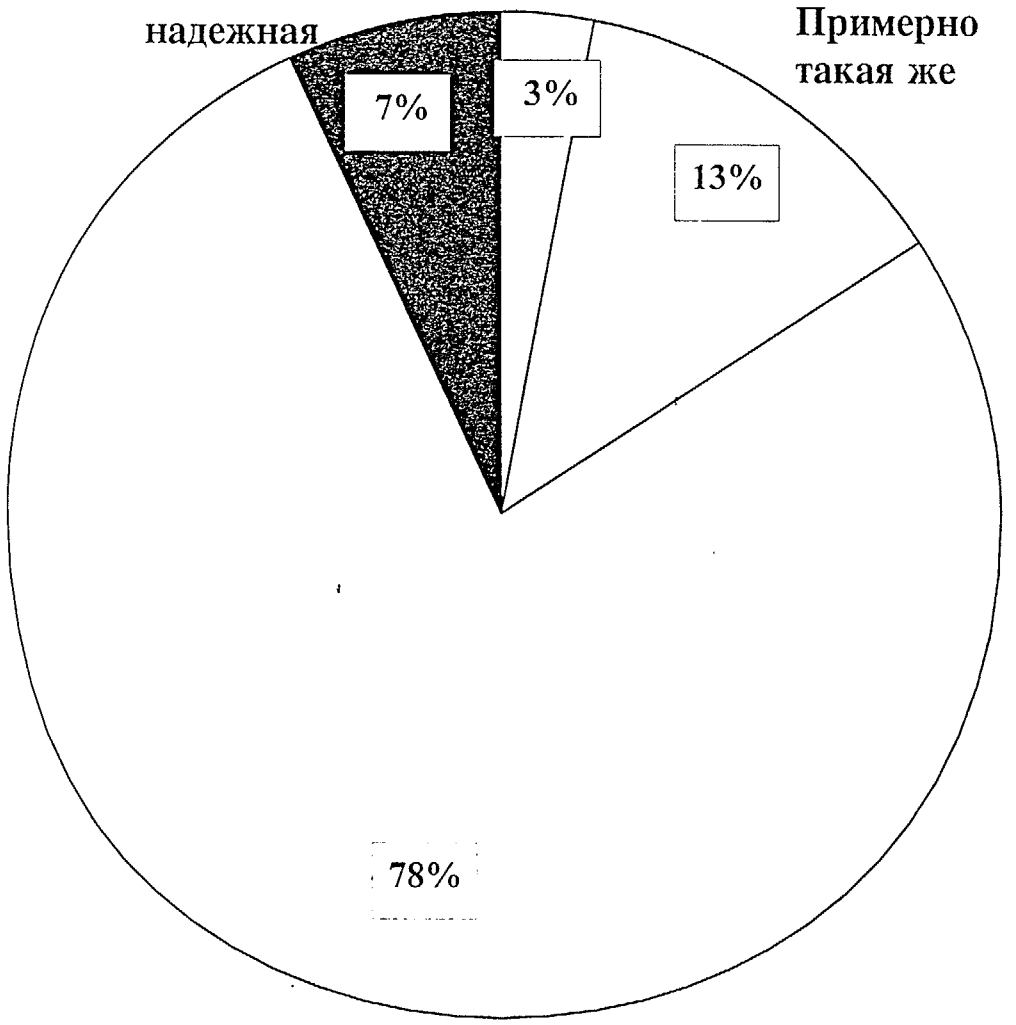


Russia Health Care Provider
#6559

Q
3-02

26

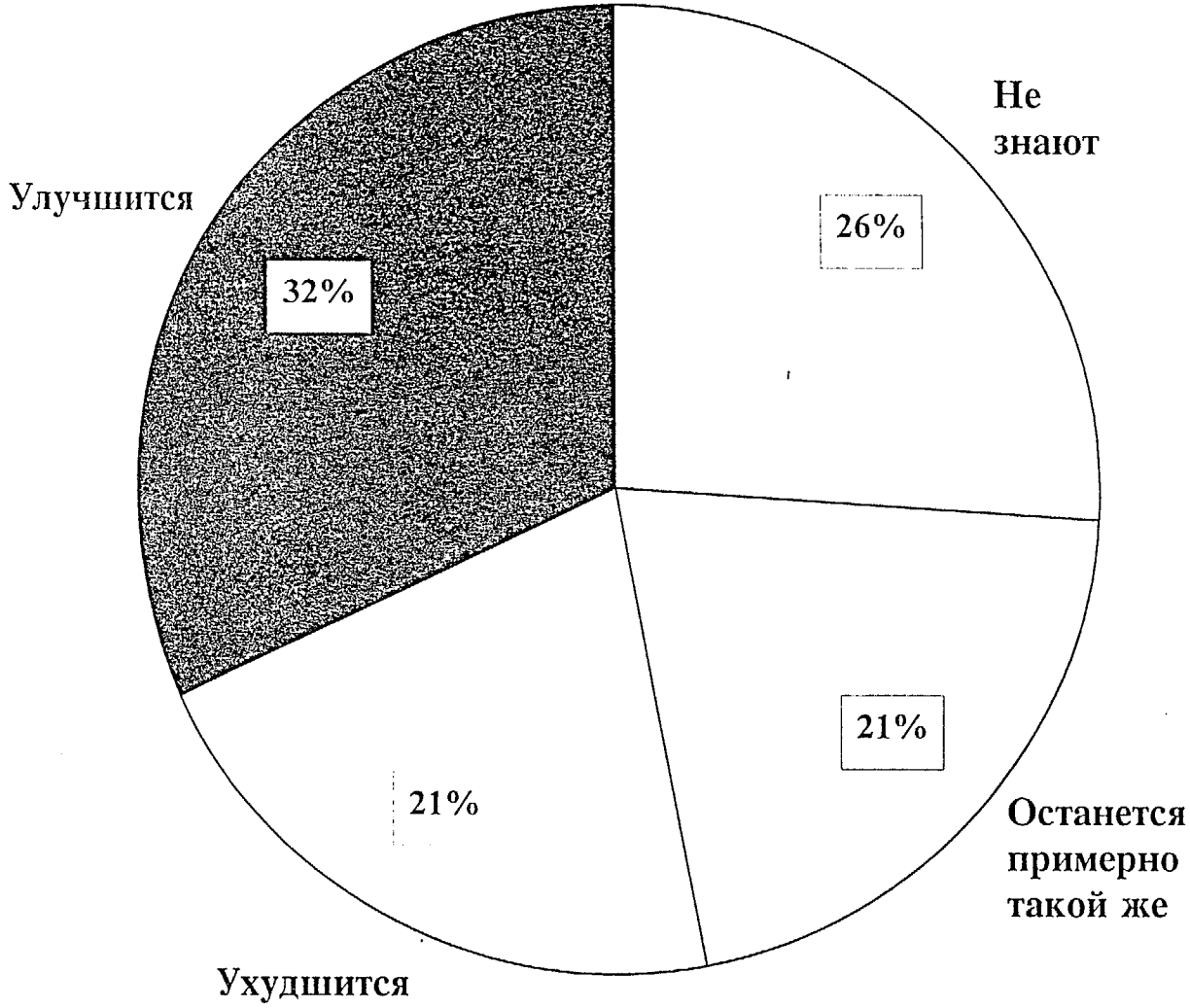
Вопрос к медикам: отличие нынешней системы здравоохранения от той, что была 10 лет назад



Russia Health Care Provider
#6559

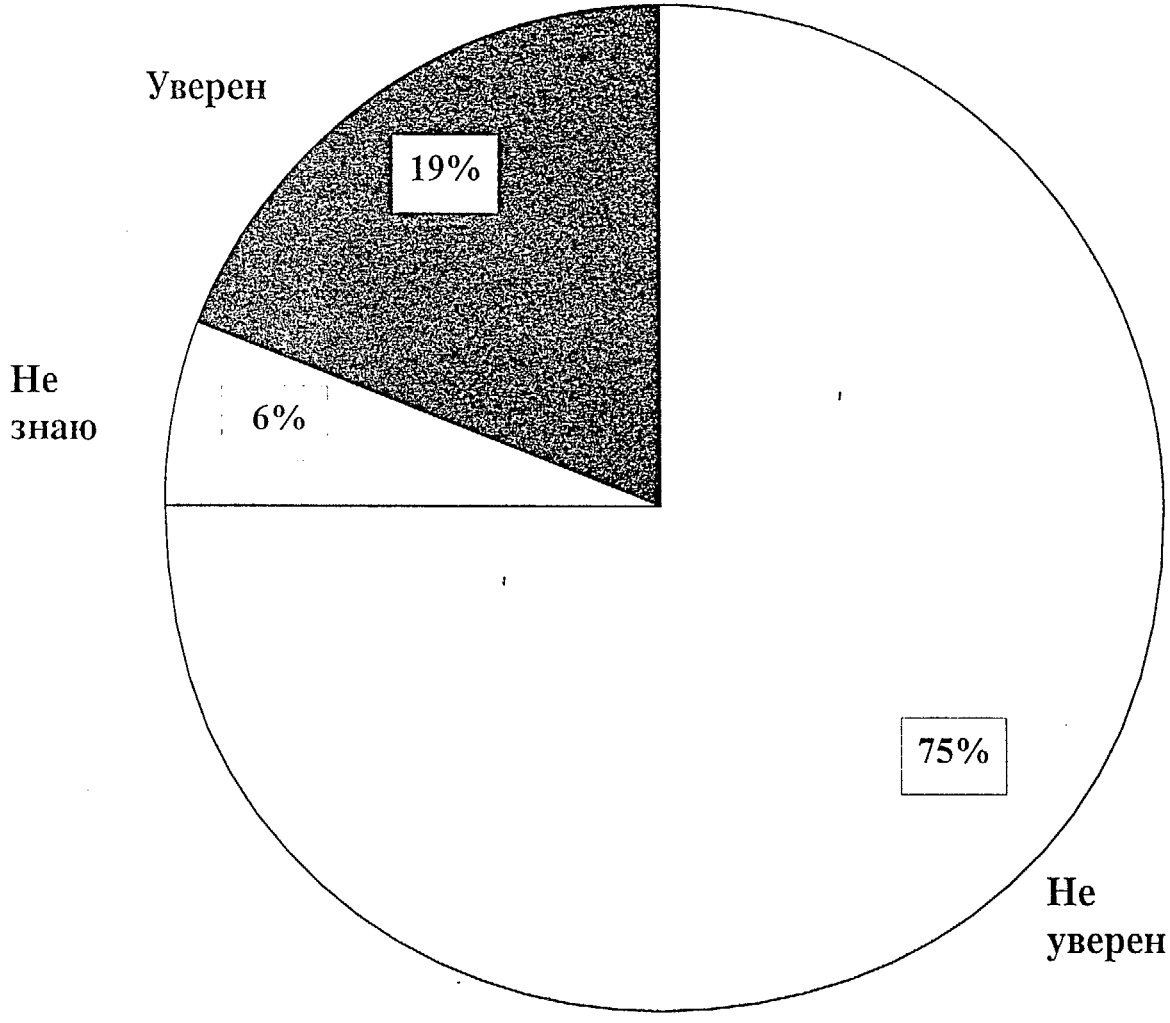
Q
4

Что произойдет с системой здравоохранения в России в следующие 10 лет?

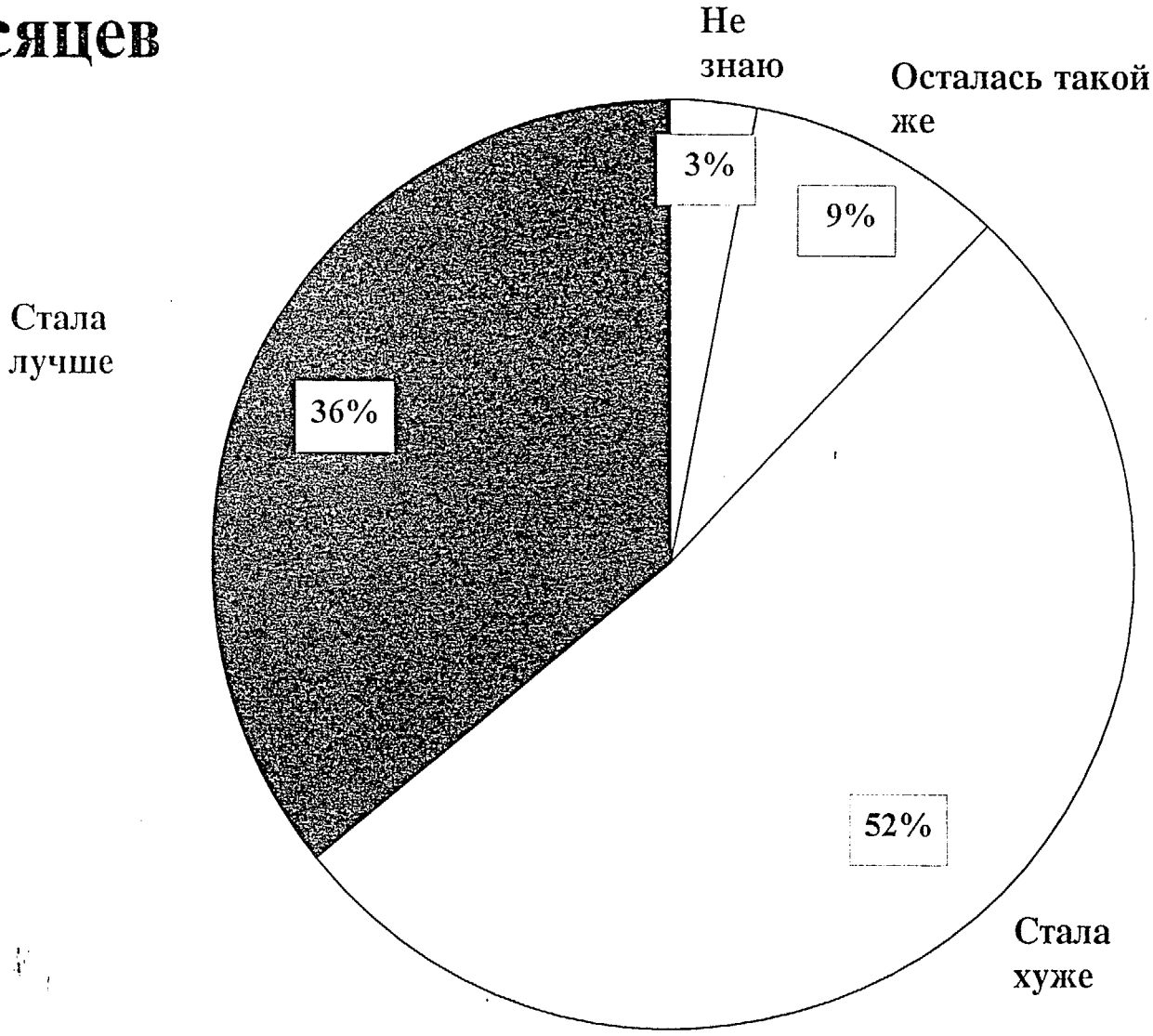


Russia Health Care Consumer #6544

Уверены ли Вы, что врач сможет Вам помочь?

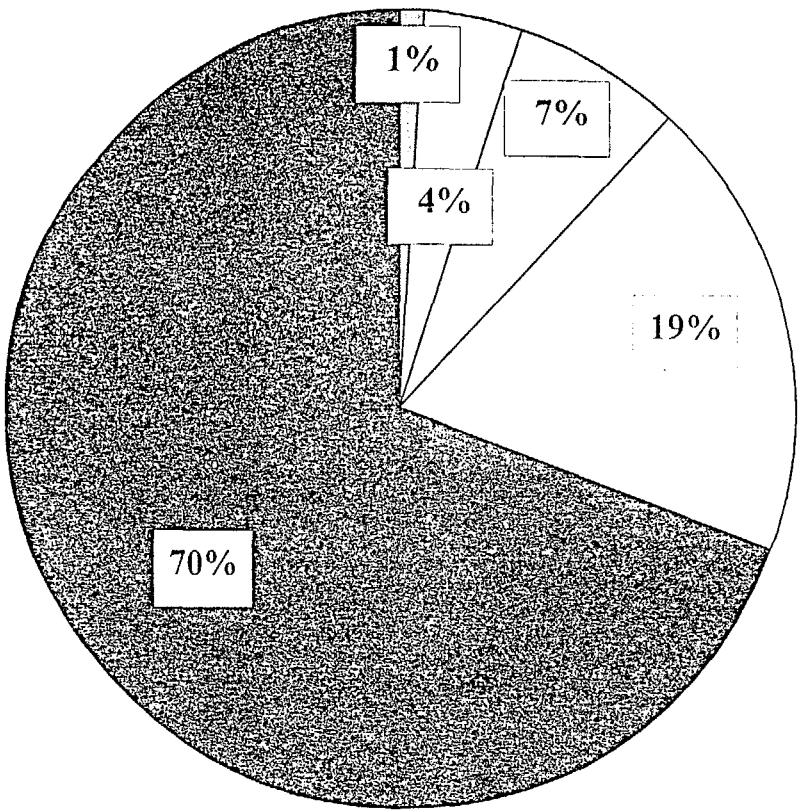


Обеспеченность лекарствами за последние 12 месяцев

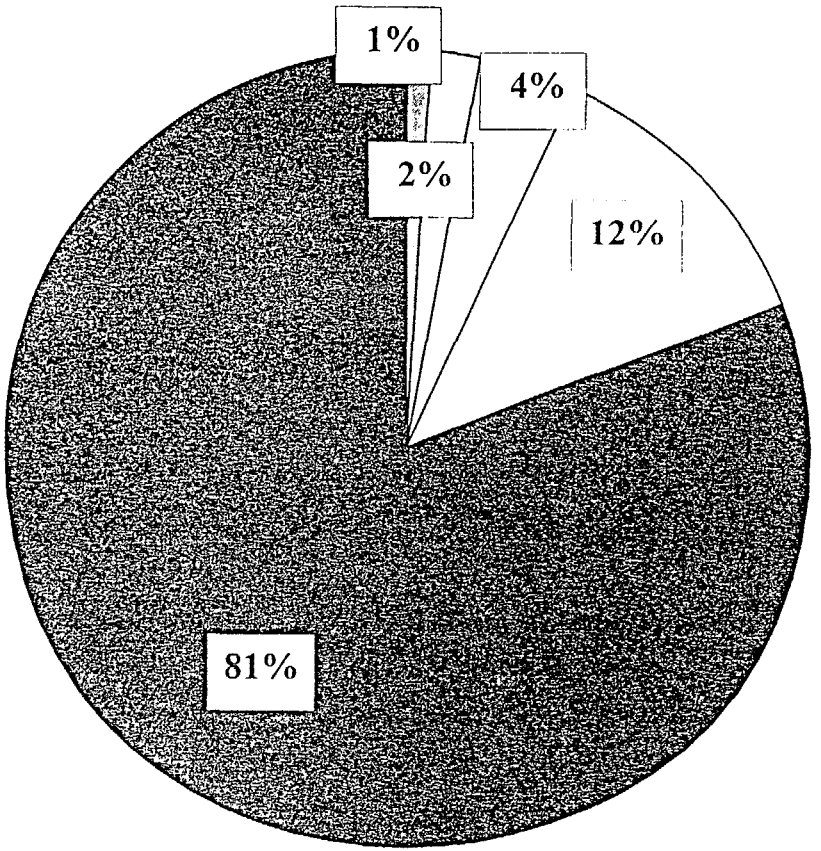


Russia Health Care Provider
#6559

Насколько Вы лично обеспокоены тем, что...



Возможно, Вам придется лично платить за медицинскую помощь членам Вашей семьи



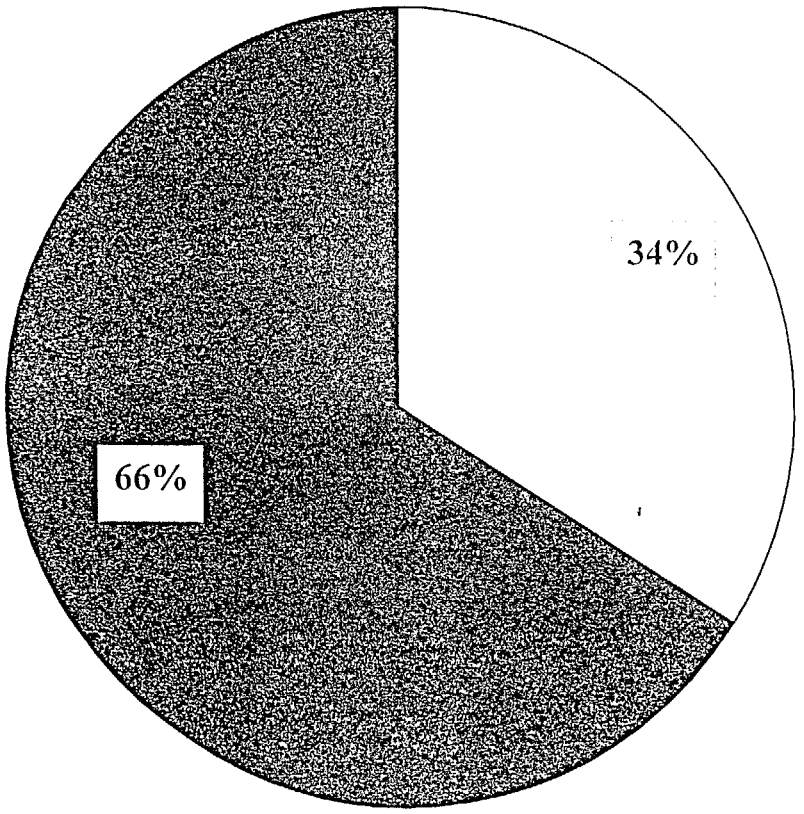
Вы не сможете платить за мед. помощь, если Вы или член Вашей семьи тяжело заболеет в будущем?

Сильно | Немного беспокоит | Не очень беспокоит | Совсем нет | Не знаю

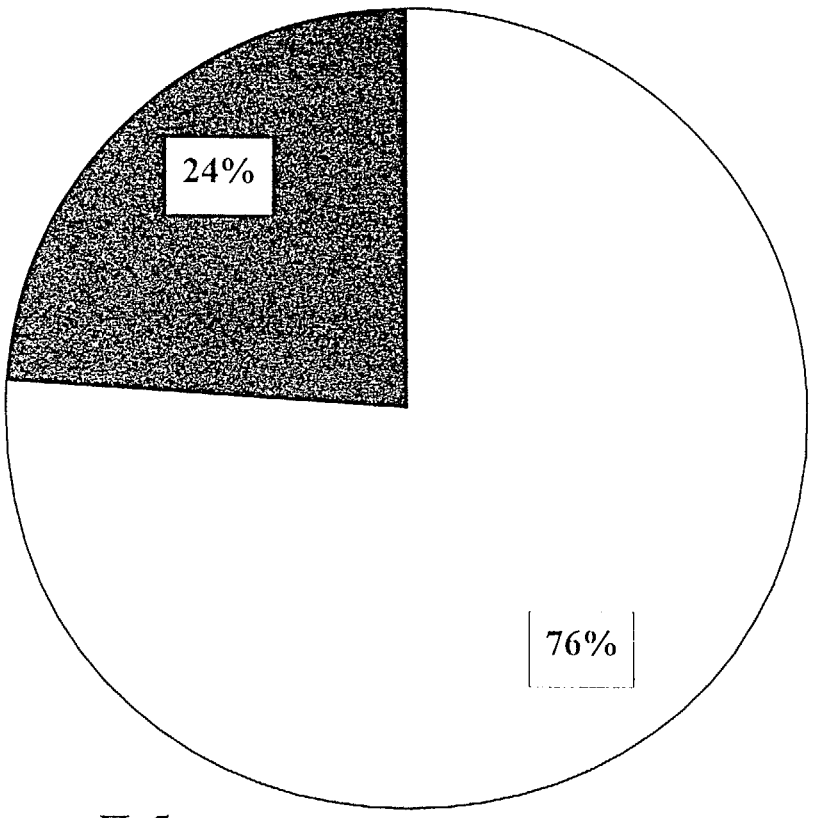
Russia Health Care Consumer #6544

Q 25-01, Q 25-02

Государственные кампании по охране здоровья



Видел, читал, слышал о госуд. образ. программах по охране здоровья



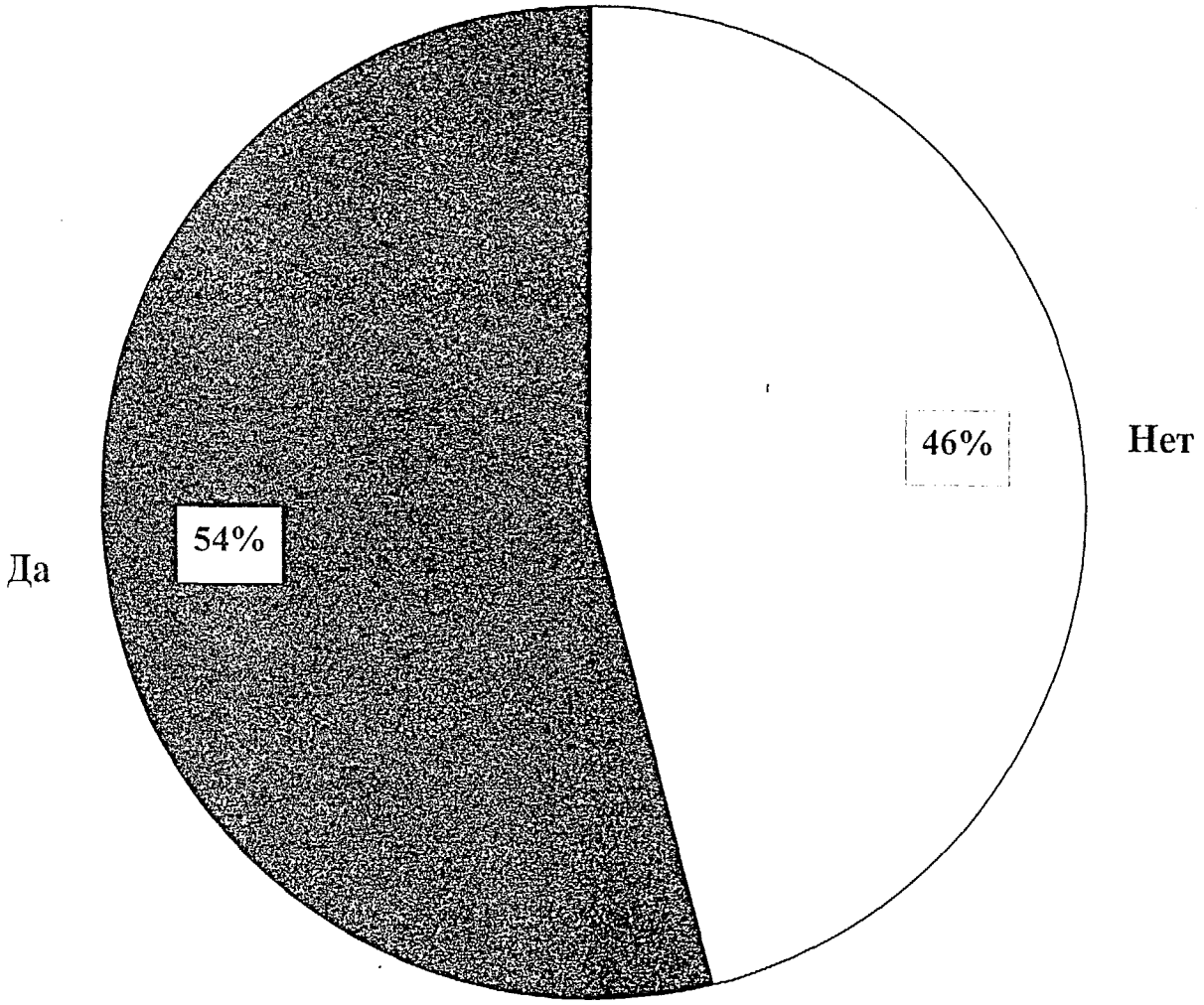
Побудят ли эти программы людей изменять привычки? (среди тех, кто слышал, читал или видел образоват. программы)

Да Нет

Russia Health Care Consumer #6544

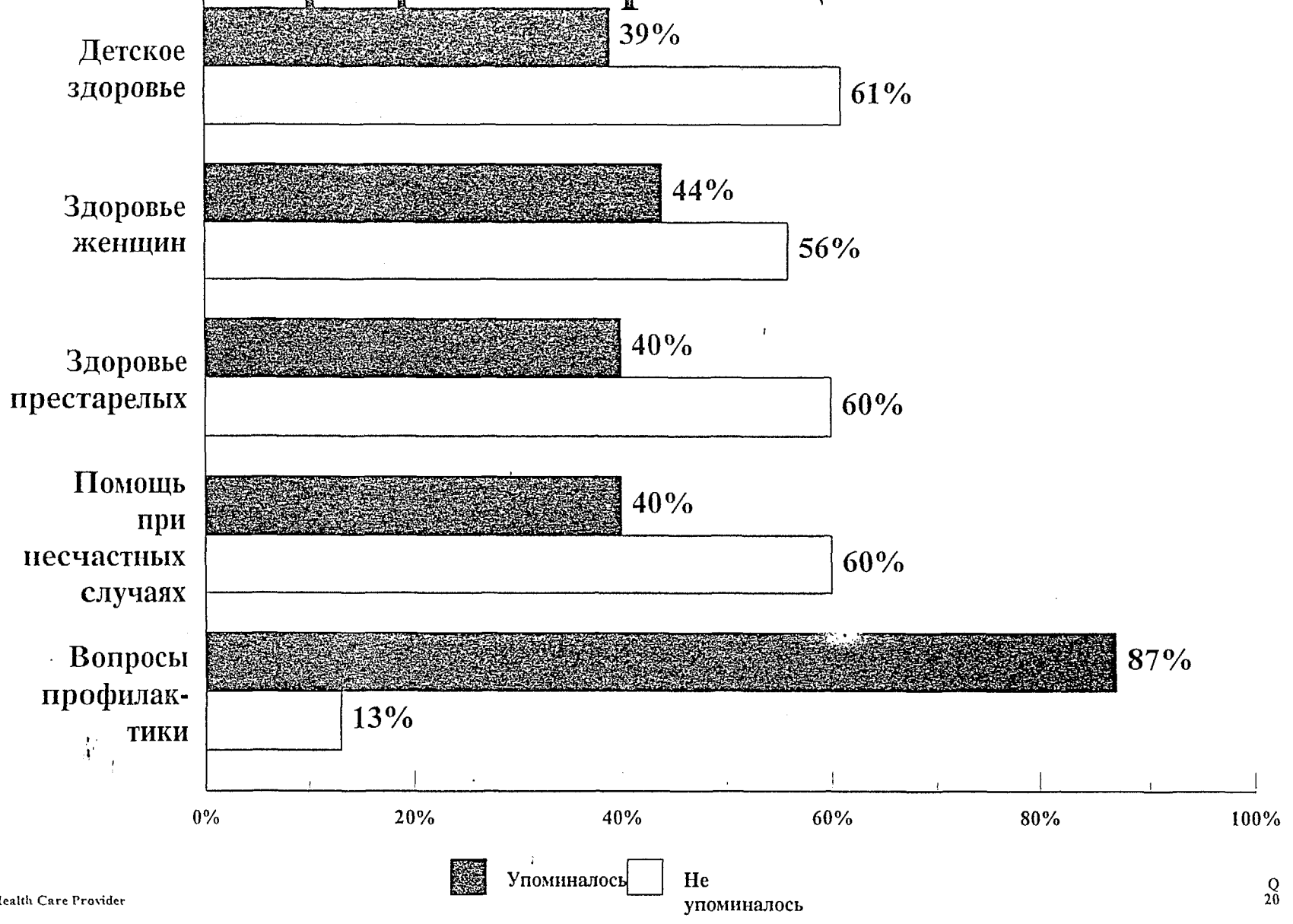
Q 29, Q 30

Участвуете ли Вы в общественных программах по здравоохранению?



Russia Health Care Provider
#6559

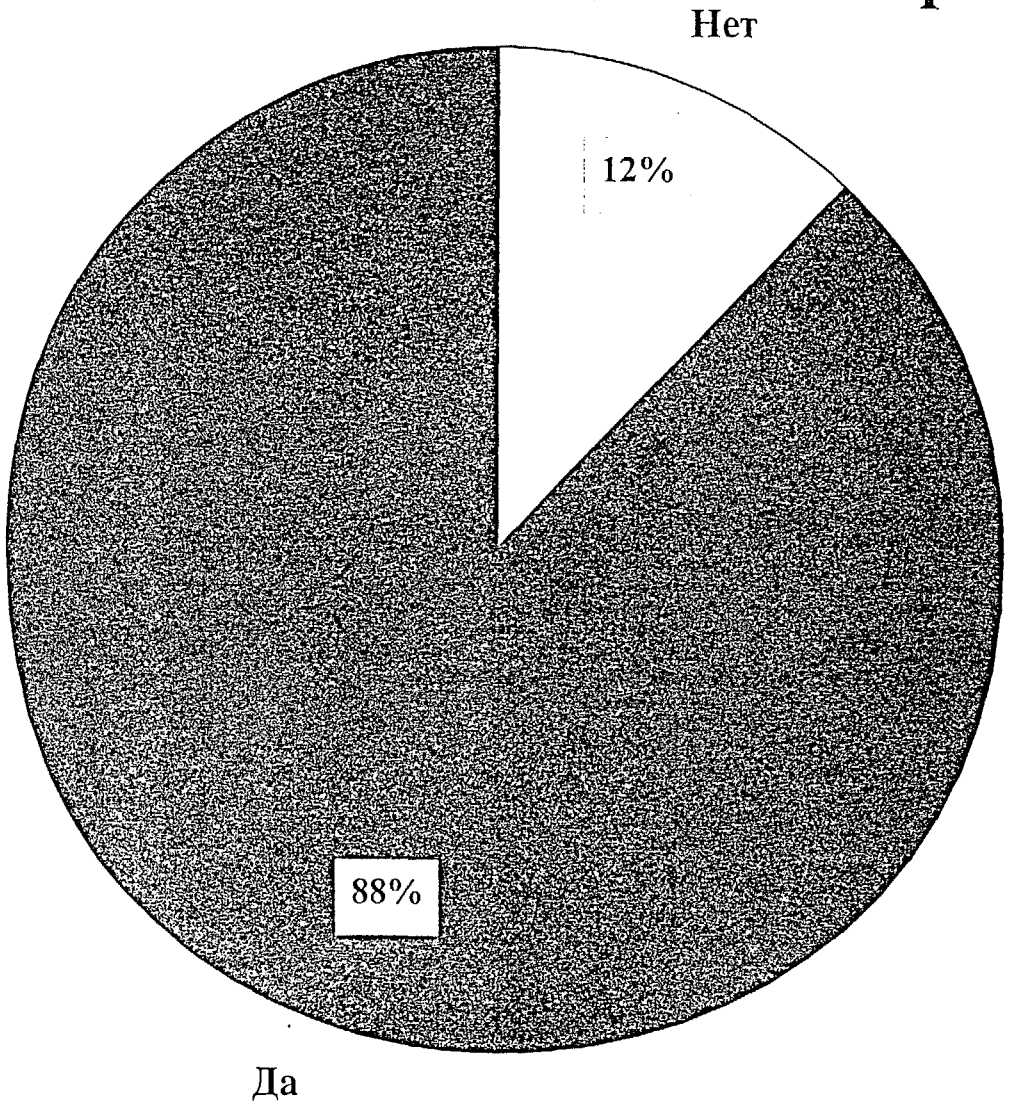
По каким медицинским проблемам проводилась программа просвещения?



Russia Health Care Provider
#6559

Q
20

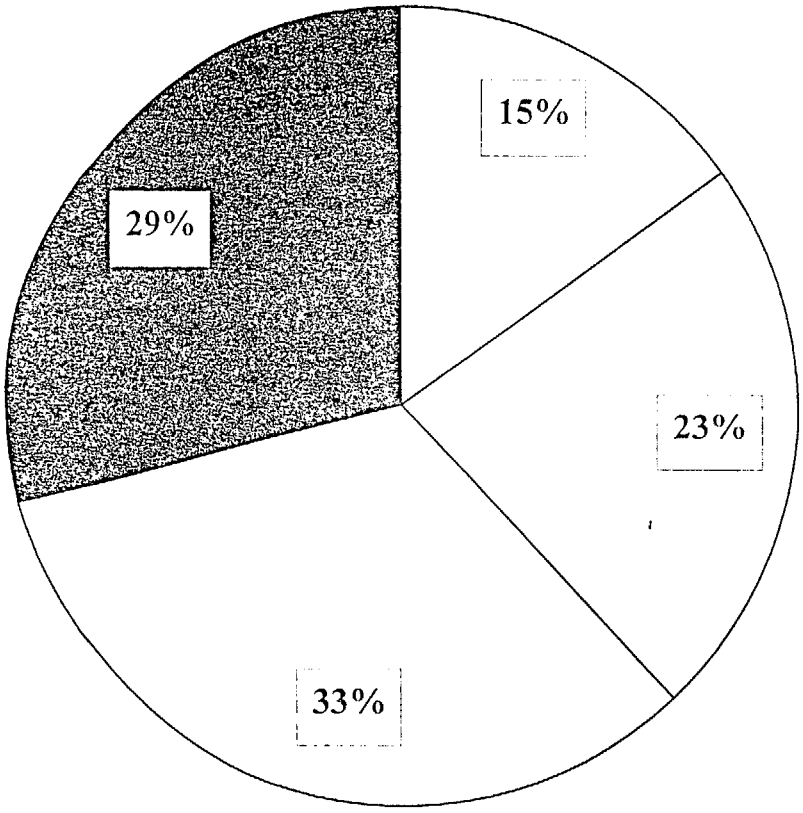
Приходилось ли Вам видеть, слышать или читать о новых гос. законах о медицинском страховании ?



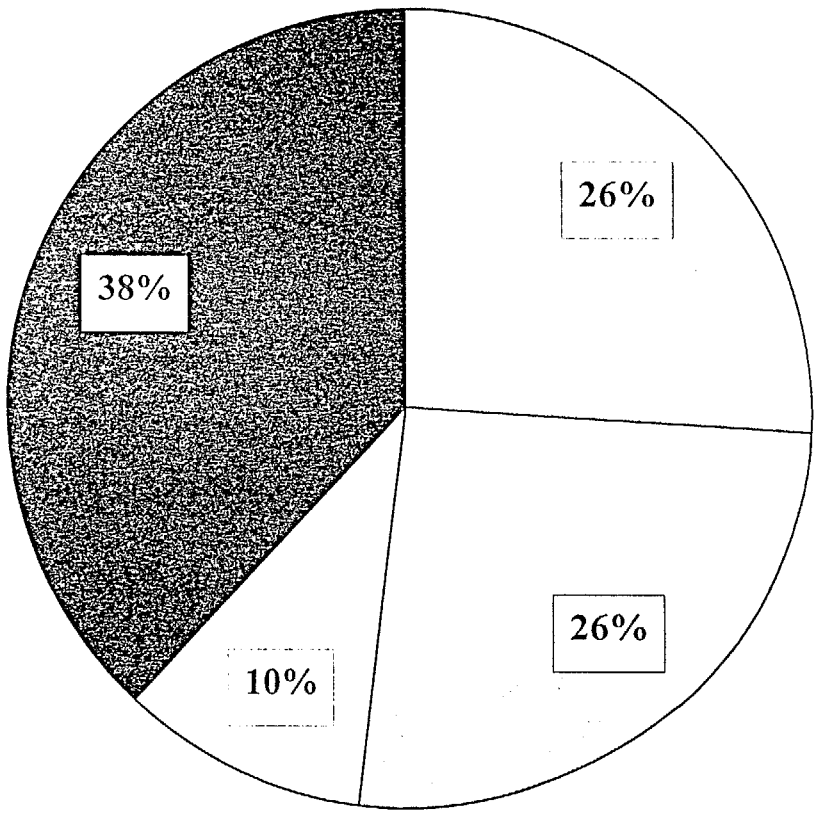
Russia Health Care Provider
#6559

Q
8

Улучшит ли новая гос. программа страхования мед. обслуживание? (среди тех, кто слышал, видел или читал о законе)



Медицинские работники



Потребители мед. услуг

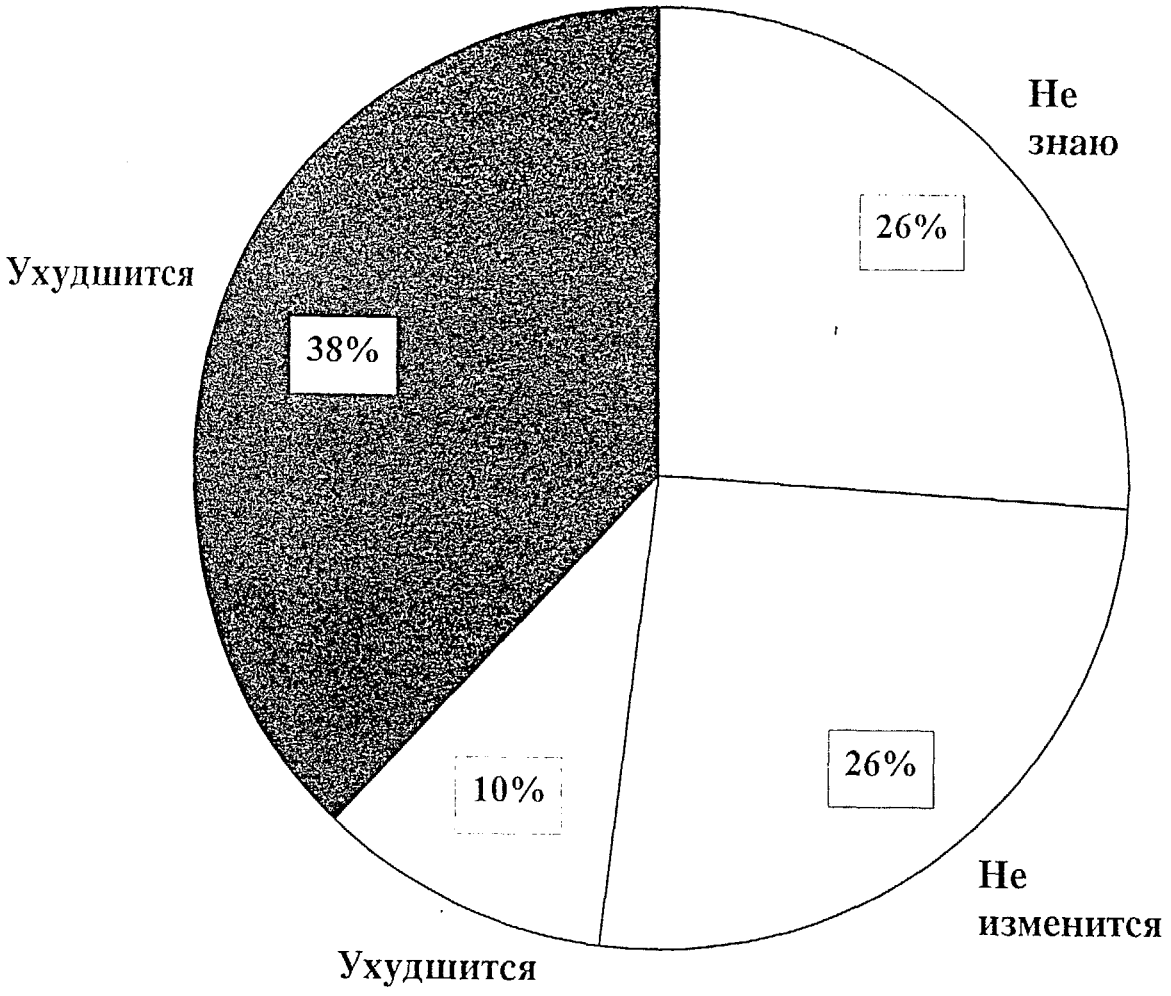
Улучшит | Ухудшит | Не изменит | Не знаю

Russia Health Care Provider
#6559

Q 9 Provider
Q 28
Consumer

Приведет ли новый закон к улучшению или ухудшению здравоохранения ?

(среди тех, кто слышал, видел или читал о законе)



Russia Health Care Consumer #6544

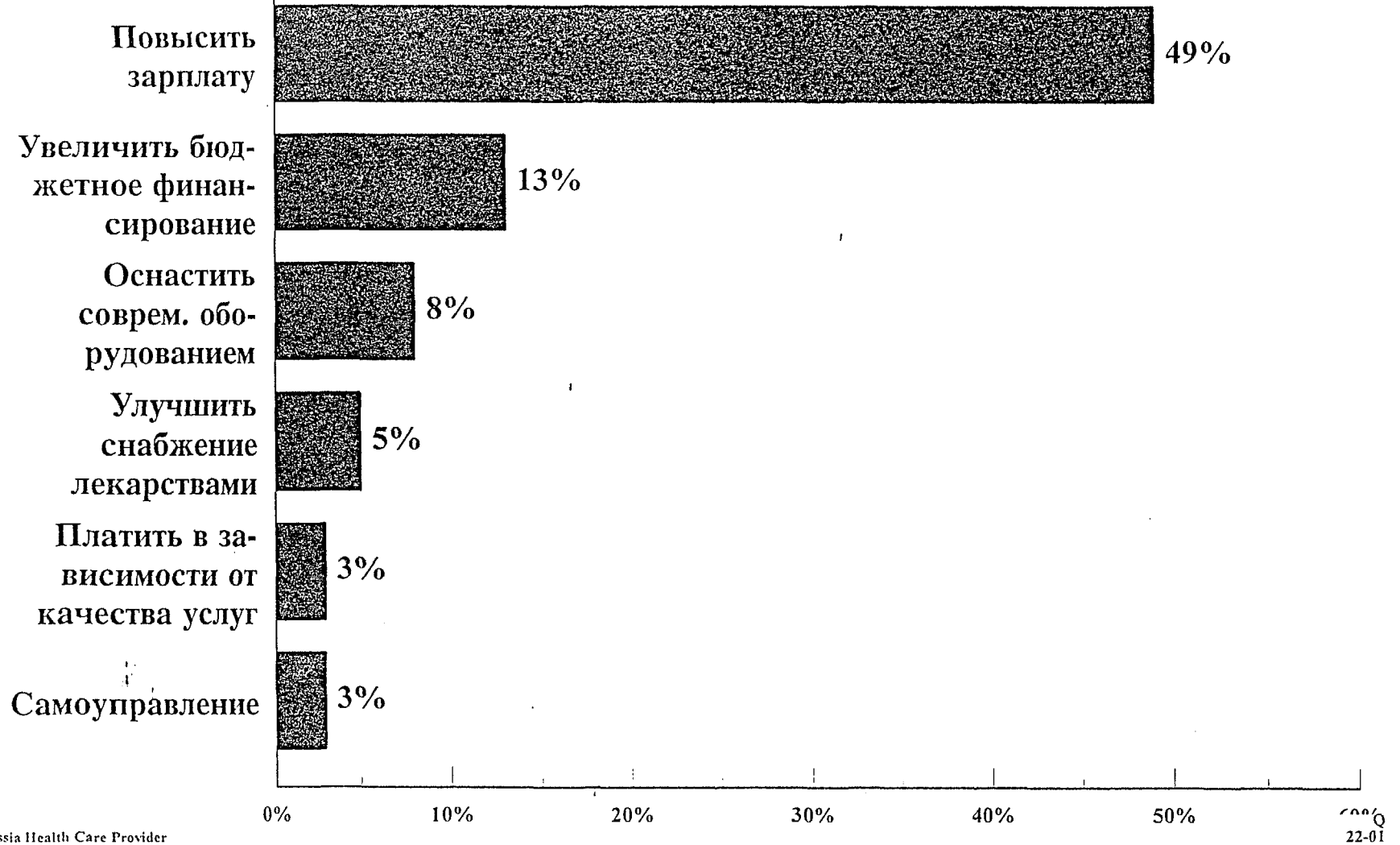
Q 28

Какие стимулы необходимы ?

Выбрать 1 вариант ответа

(среди ответивших отрицательно/затруднившихся ответить)

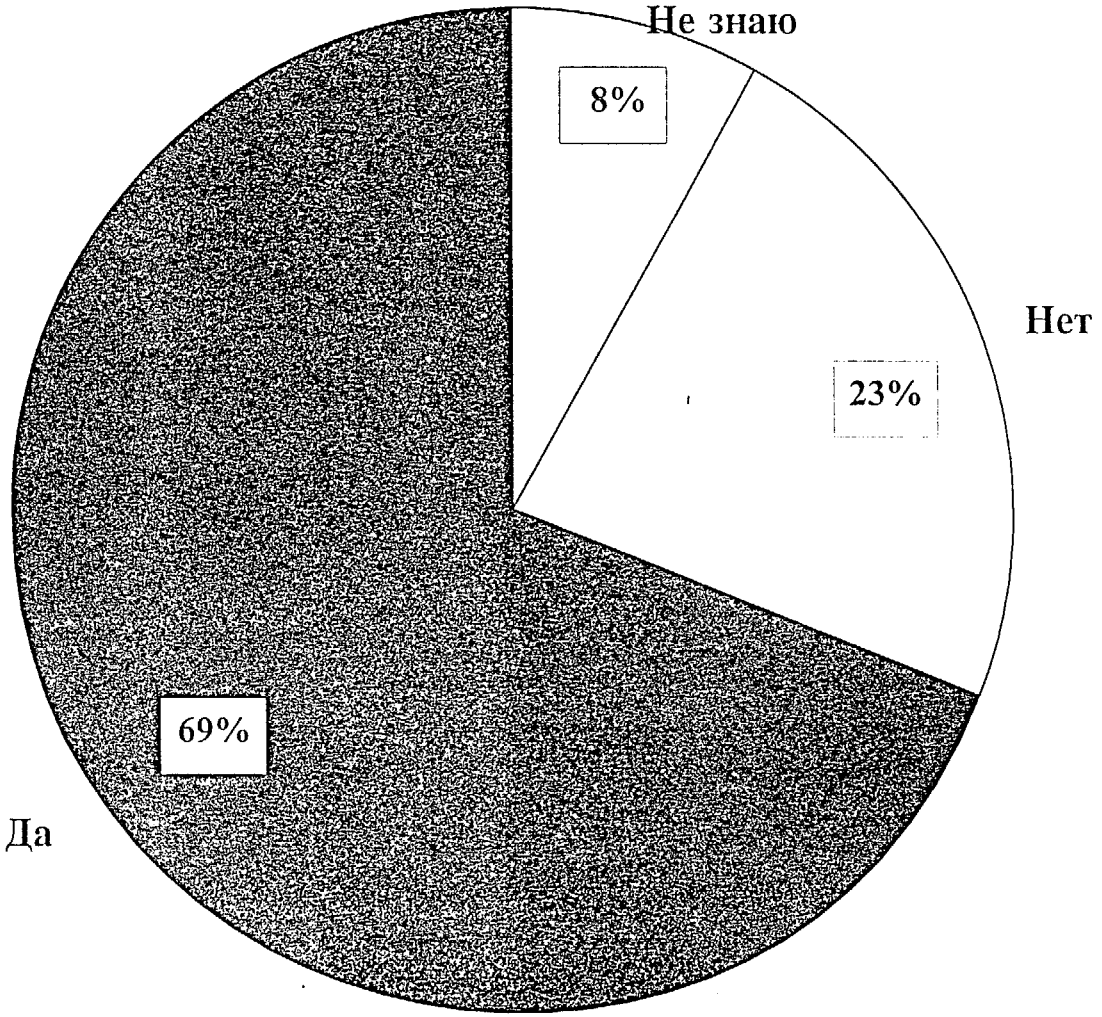
Первый выбранный стимул



Russia Health Care Provider
#6559

22-01

Приведет ли конкуренция к улучшению качества мед. обслуживания и снижению цен?

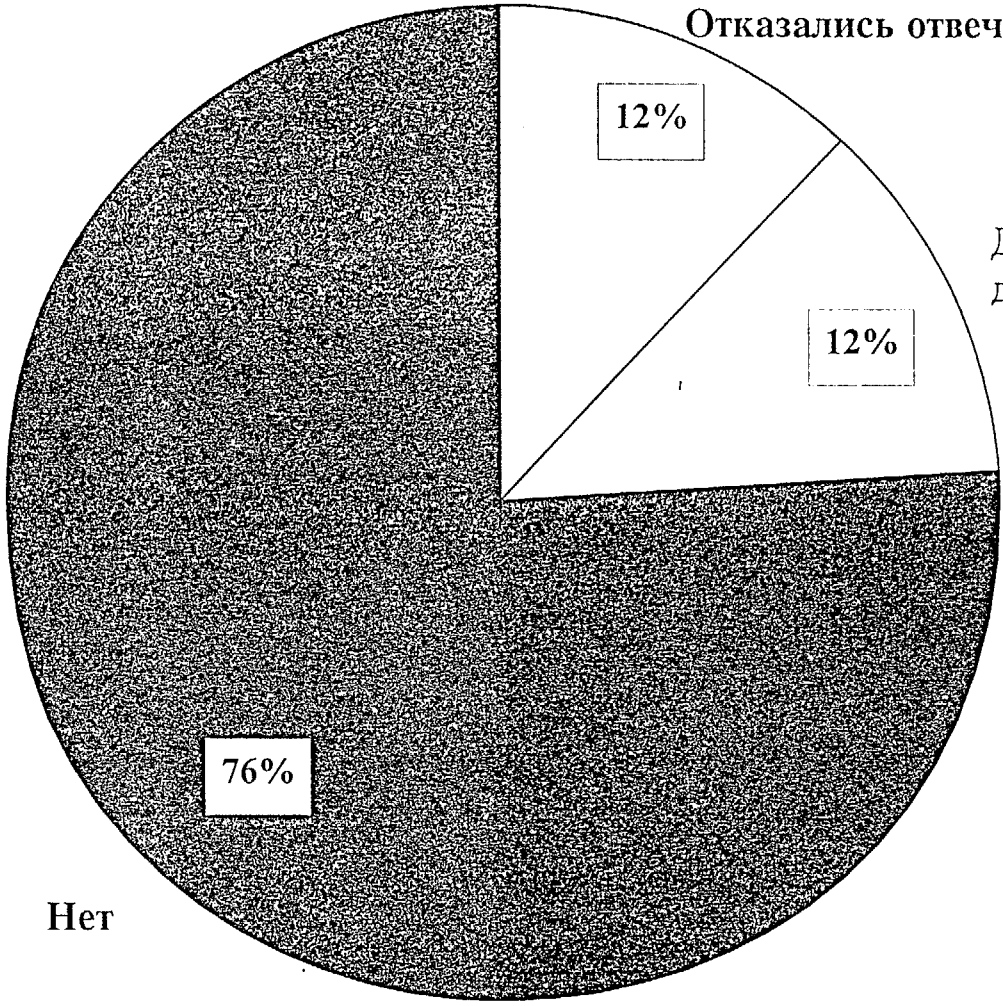


Russia Health Care Provider
#6559

Q
23

589

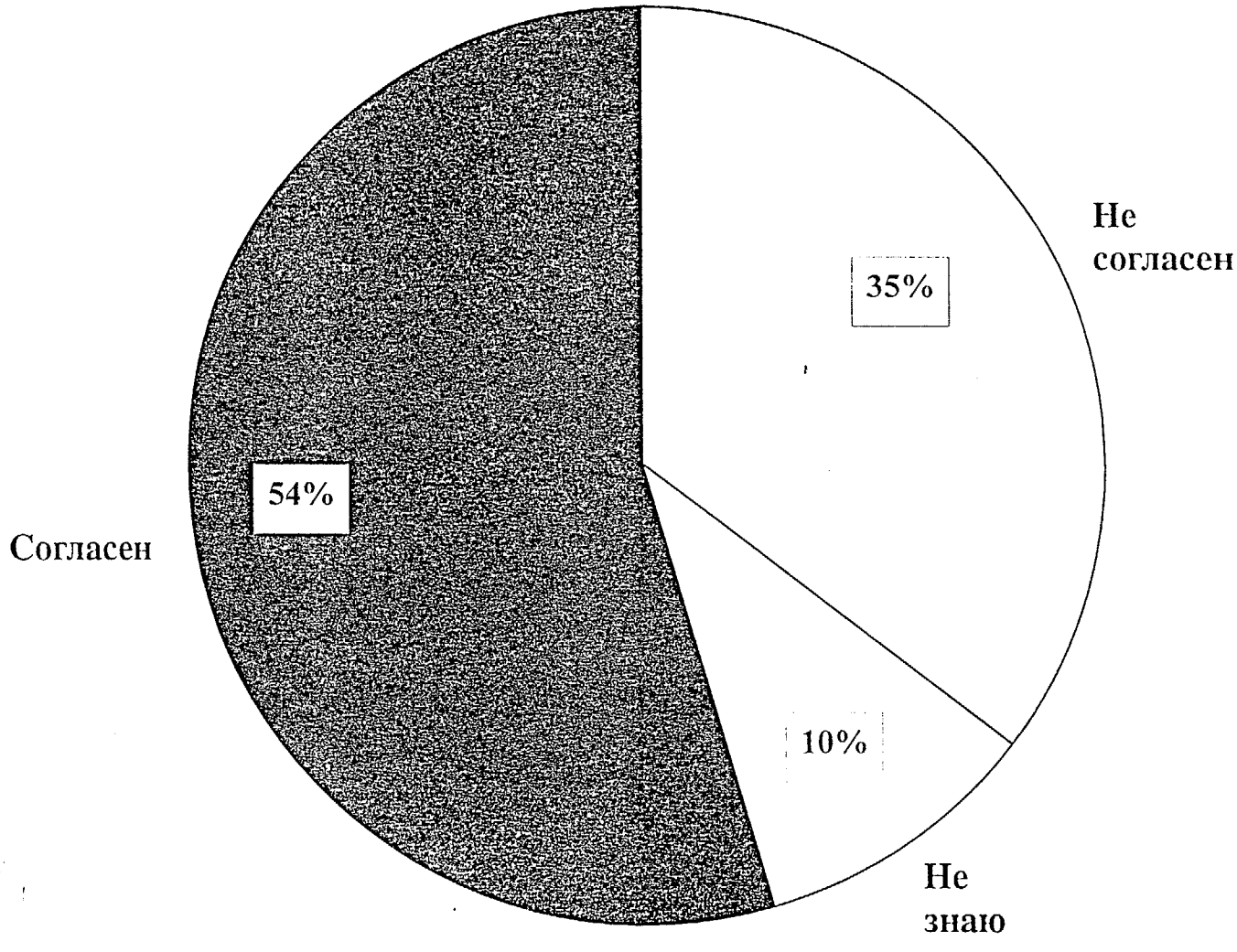
Получаете ли Вы доход за счет оказания платных мед. услуг ?



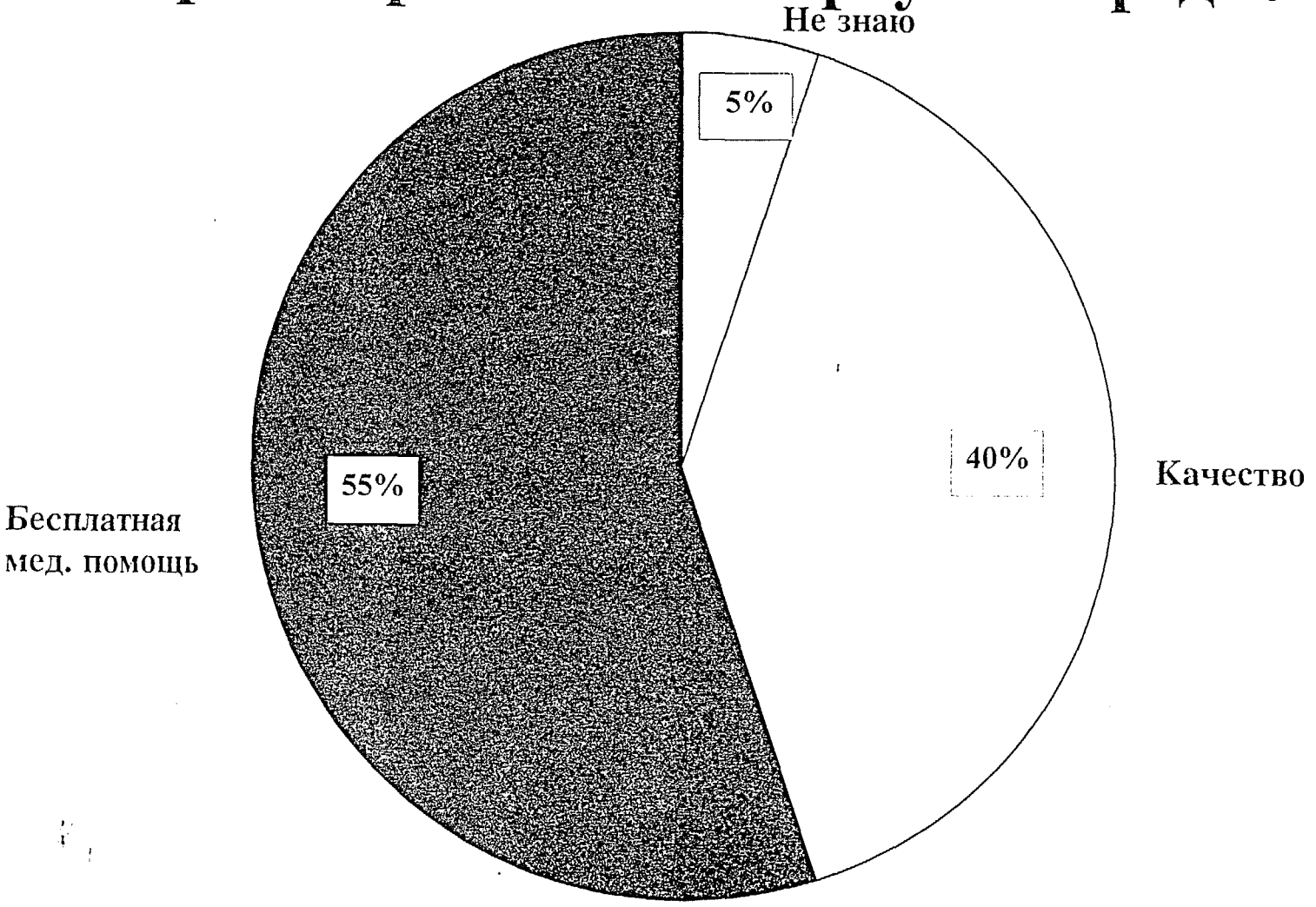
Russia Health Care Provider
#6559

59

"Существующая система здравоохранения в России - хорошая, а существующие сегодня проблемы - лишь временное явление"



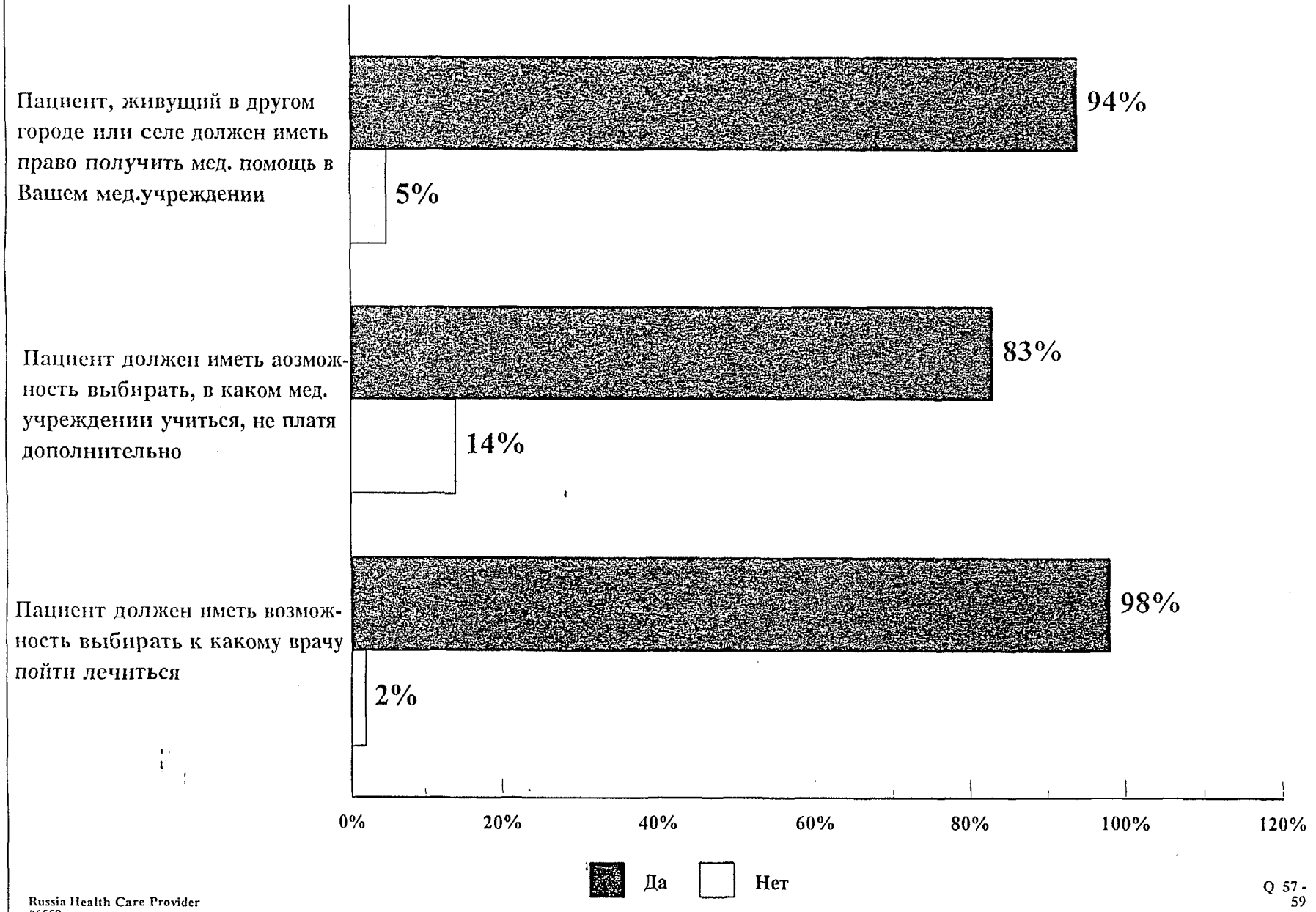
Какая черта должна быть присуща здравоохранению в первую очередь?



Russia Health Care Consumer #6544

Q 36

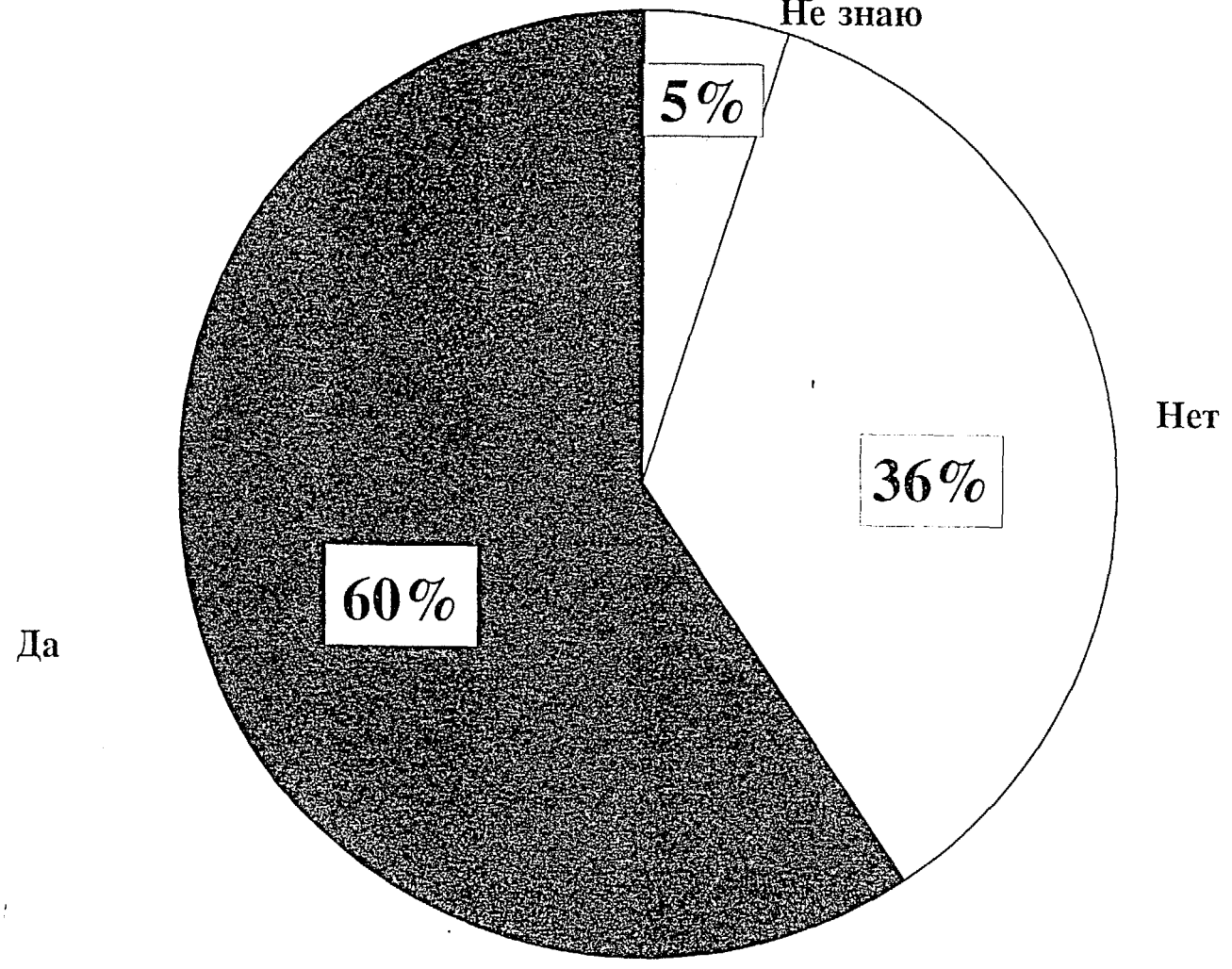
Выбор пациентом медицинского учреждения



Russia Health Care Provider
#6559

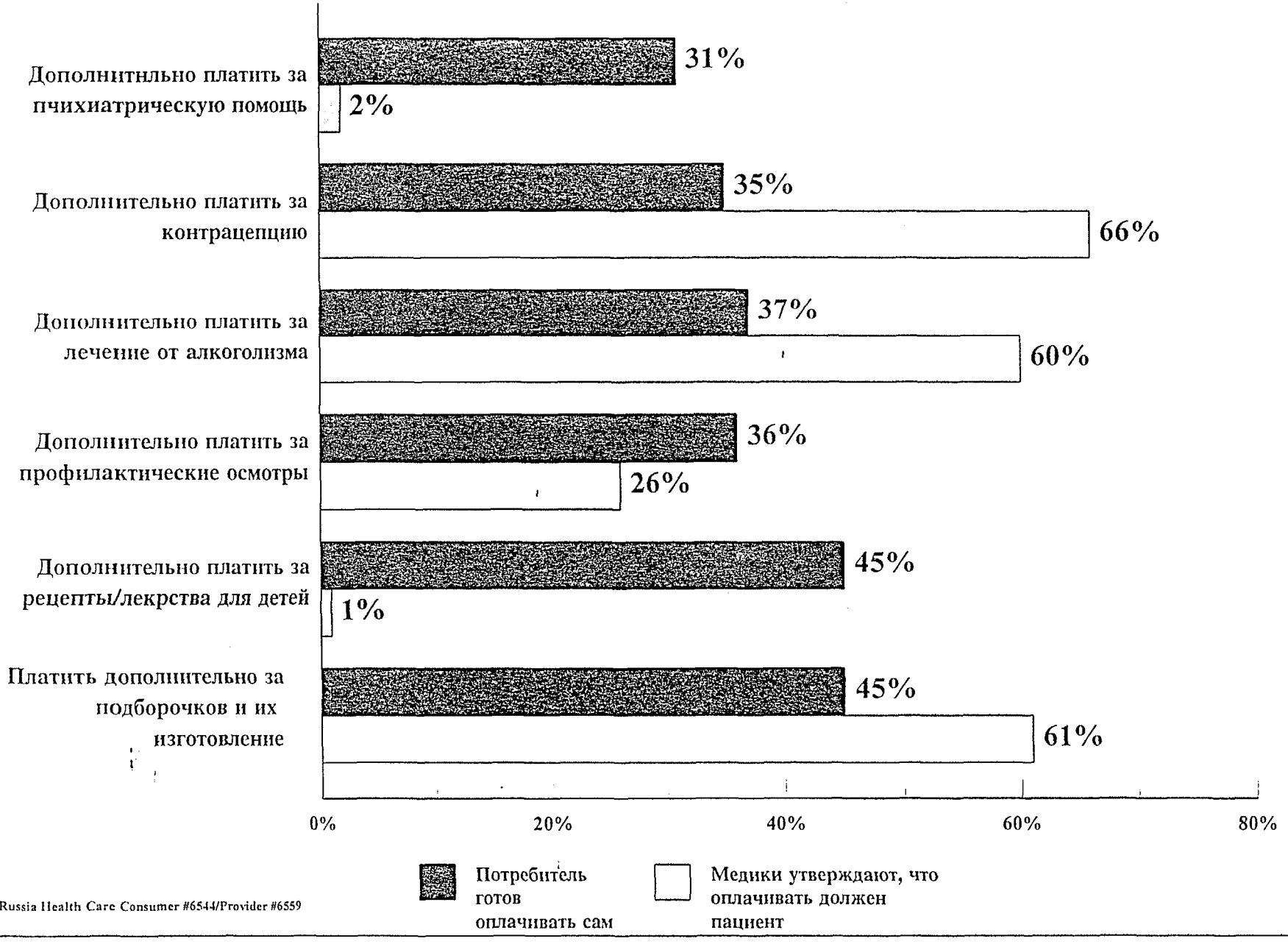
Q 57 - 59

Согласитесь ли Вы с ограниченным доступом к мед. услугам в связи с их платностью для того, чтобы гарантировать качественное мед. обслуживание ?



Russia Health Care Consumer #6544

Готовность платить за медицинские услуги

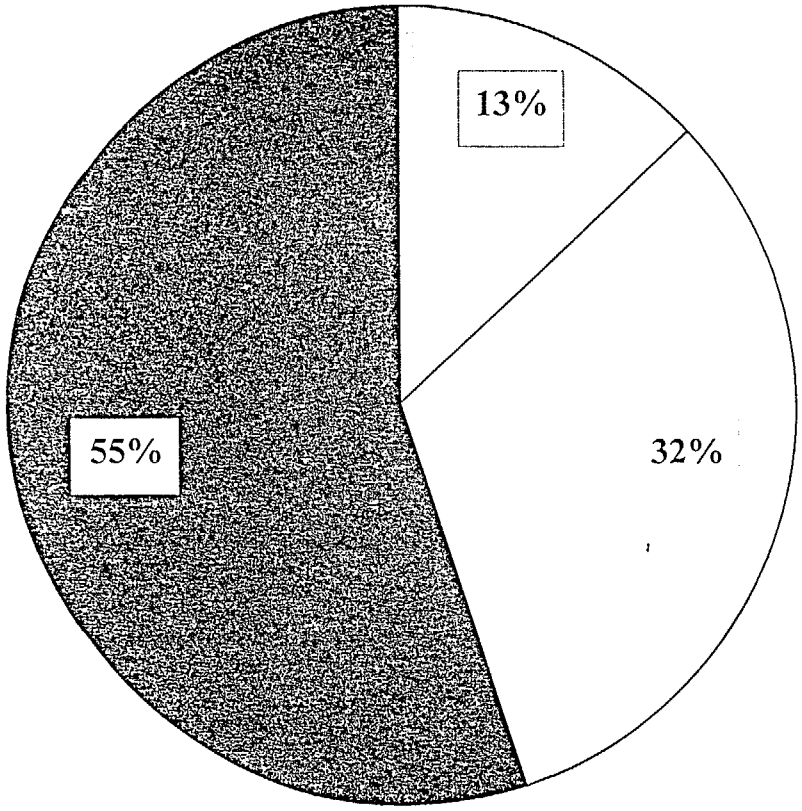


Russia Health Care Consumer #6544/Provider #6559

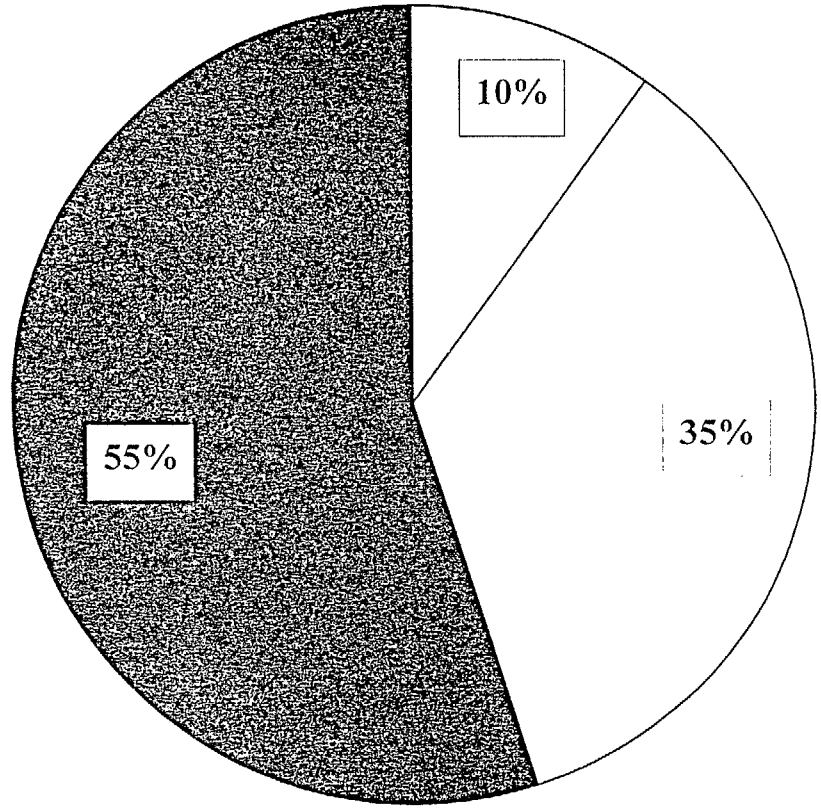
Почему бы не обратиться в частную больницу или поликлинику ? (среди тех, кто не желает обращаться в частную больницу или поликлинику)

Russia Health Care Consumer #6544

Выбор медицинского учреждения в зависимости от формы собственности



"Я согласился бы посещать больницу или поликлинику "доверительного общества"



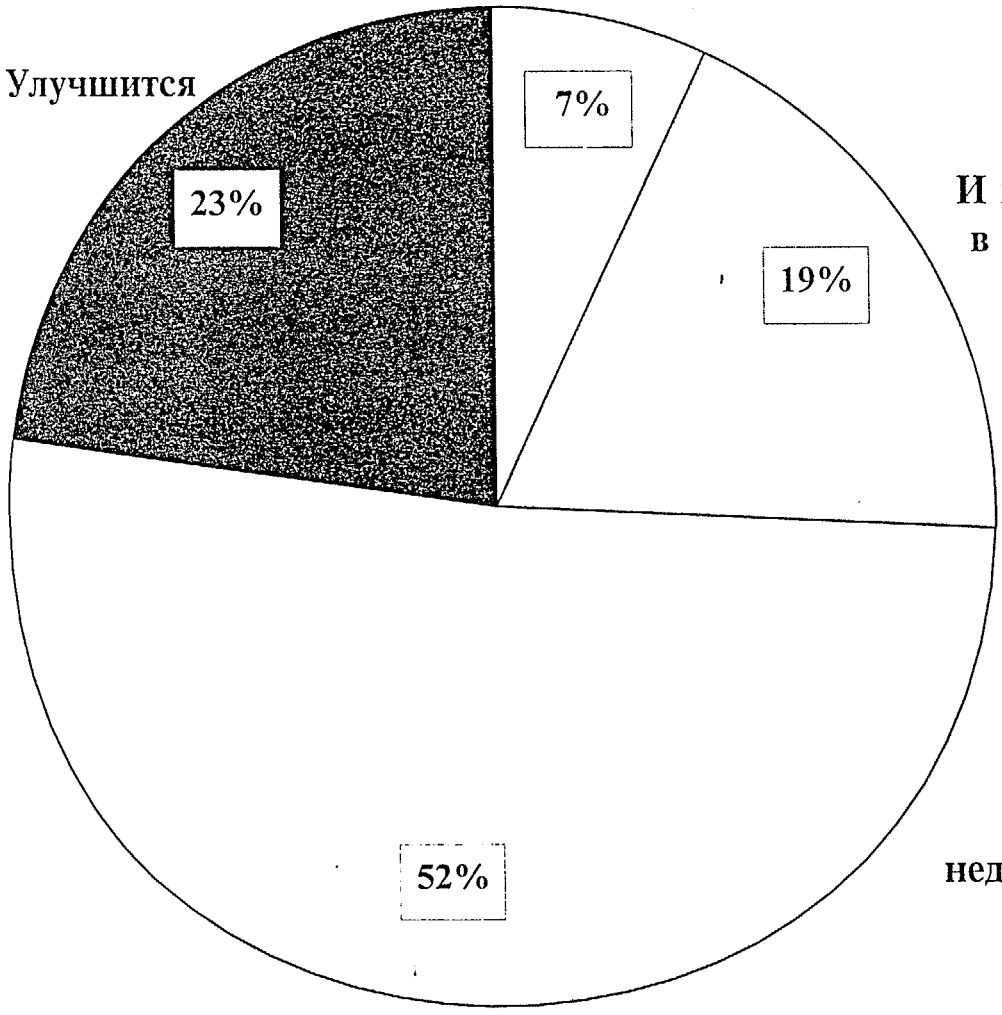
"Я согласился бы посещать частную больницу или поликлинику"

Согласен | Не согласен | Не знаю

Russia Health Care Consumer #6544

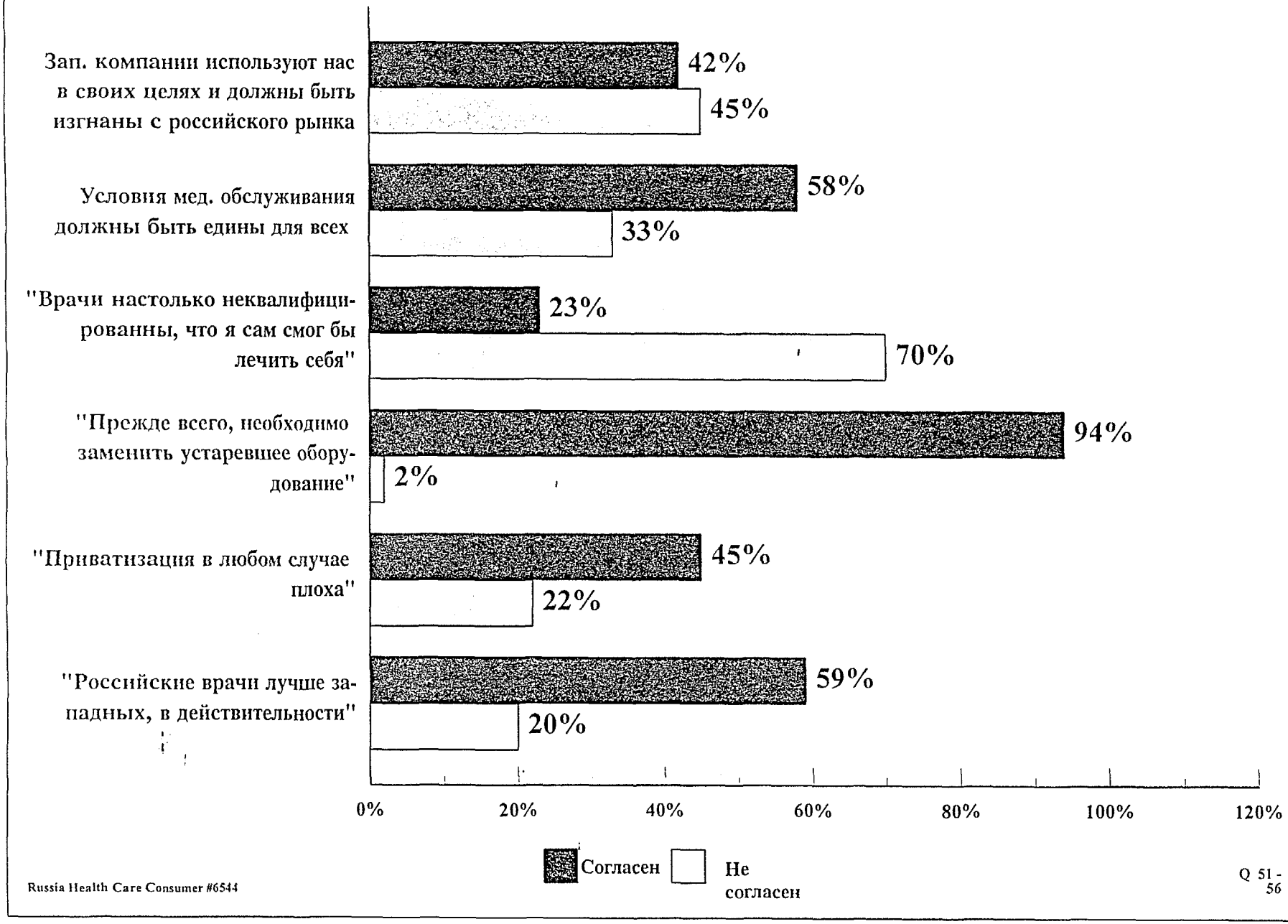
Q 47, Q 48

Точка зрения на то, как изменится система здравоохранения,если позволить частным лицам и организациям управлять мед.учреждениями



Russia Health Care Consumer #6544

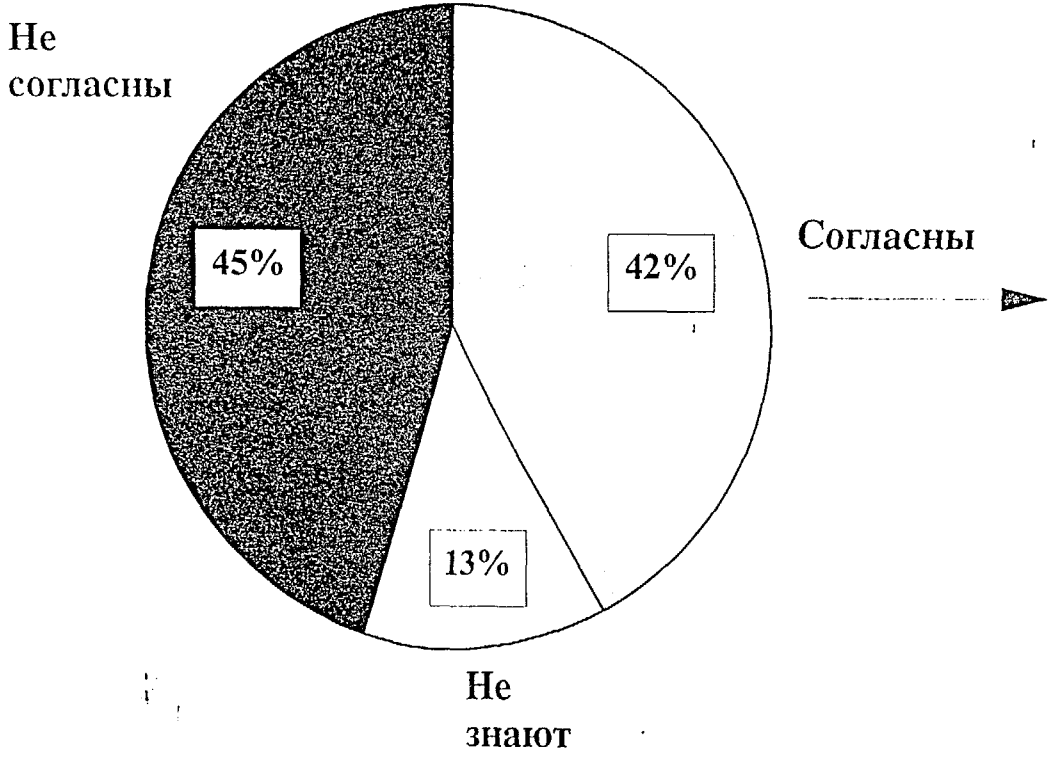
Взгляды на здравоохранение



Russia Health Care Consumer #6544

Q 51 - 56

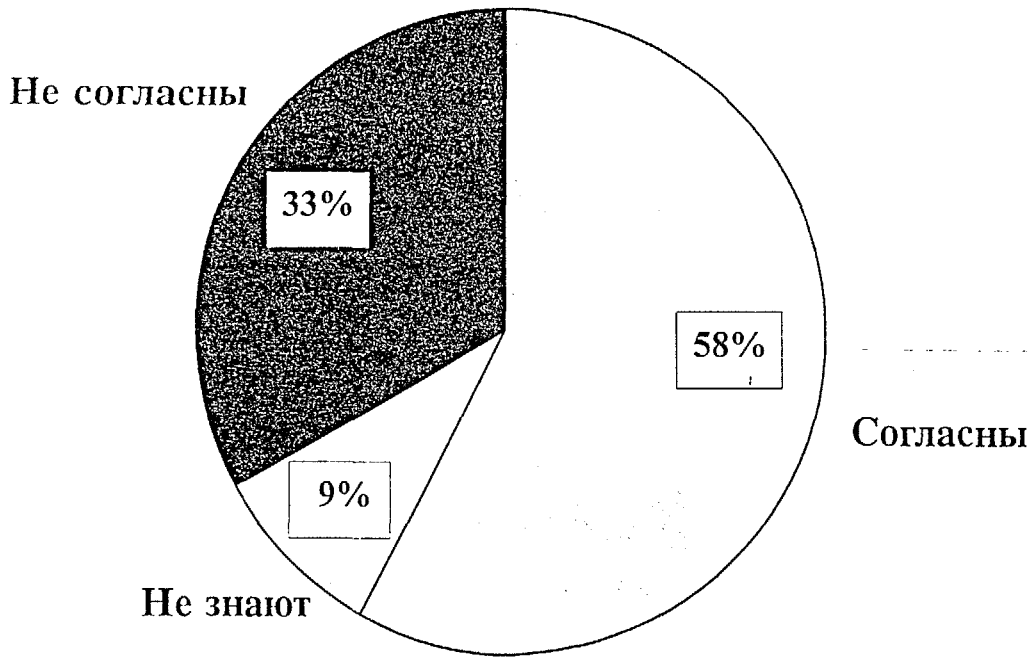
Западные фармацевтические компании эксплуатируют рабочую силу, им необходимо помешать



ОСНОВНЫЕ ГРУППЫ:

- Престарелые 49%
- Рабочие 47%
- Респонденты с низкими доходами 48%
- Те, кто полагают, что система будет ухудшаться 48%

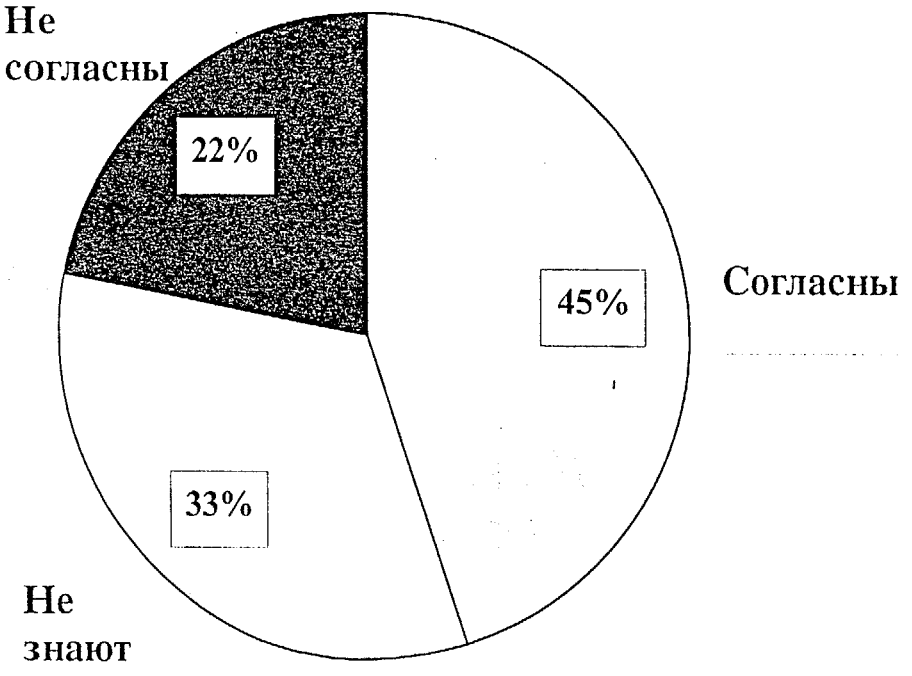
Медицинское обслуживание должно быть едино для всех



ОСНОВНЫЕ ГРУППЫ:

- Моложе 35 лет 43%
- 45-54 года 64%
- 55-64 года 71%
- Пожилые 75%

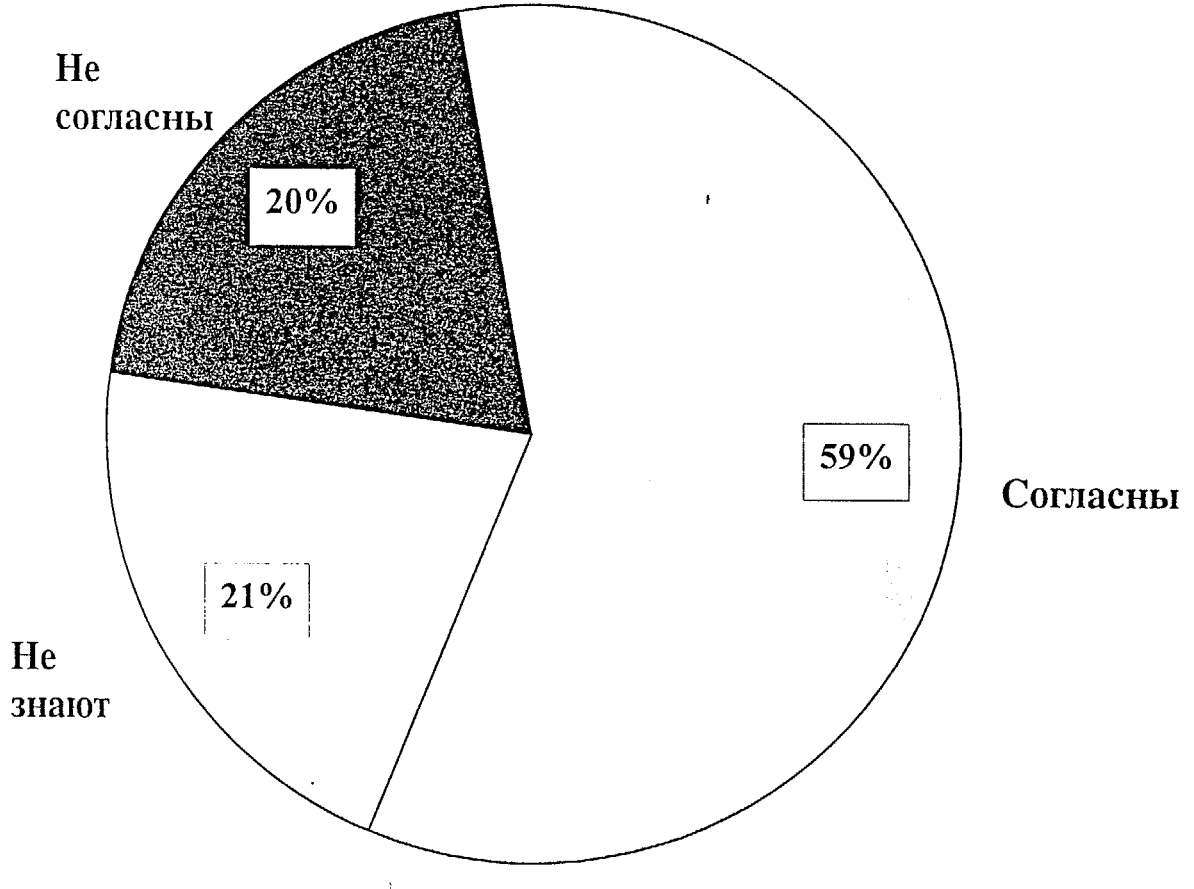
Приватизация в любом случае плоха



ОСНОВНЫЕ ГРУППЫ:

- Города с населением свыше 500 тыс.чел. 52%
- Регион Урала/Сибири 51%
- 45-54 года 54%
- ИТР 50%
- Предсказывающие ухужшение системы здравоохранения в следующие 10 лет 53%

Российские врачи лучше западных, потому что они могут оказывать людям помощь даже без современных лекарств и дорогого оборудования



II группа населения, выделяемая по отношению к реформе

Удовлетворенные существующим положением и и настроенные против реформ составляют 11%

- Центральная/Северная Россия
- Некрупные города
- 65 лет и старше
- Женщины старше 45
- Пенсионеры
- Критическое настроение ослабевает с улучшением образования
- Критическое настроение ослабевает с увеличением доходов
- Те, кто отдают приоритет бесплатности мед. помощи

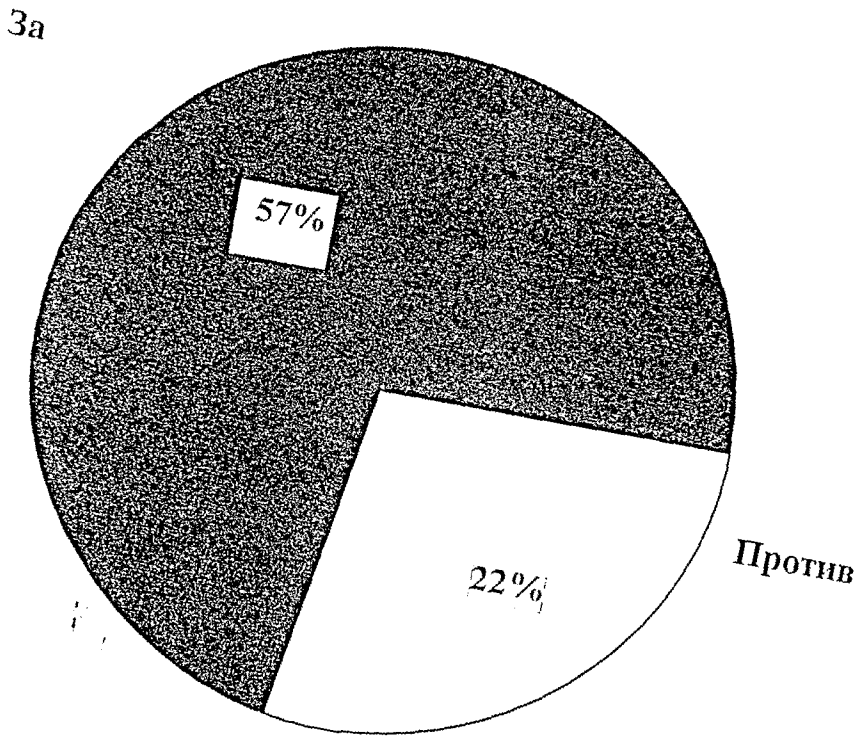
I группа населения, выделяемая по отношению к реформе

Не удовлетворенные существующим положением и более склонные к реформированию, составляют 46%

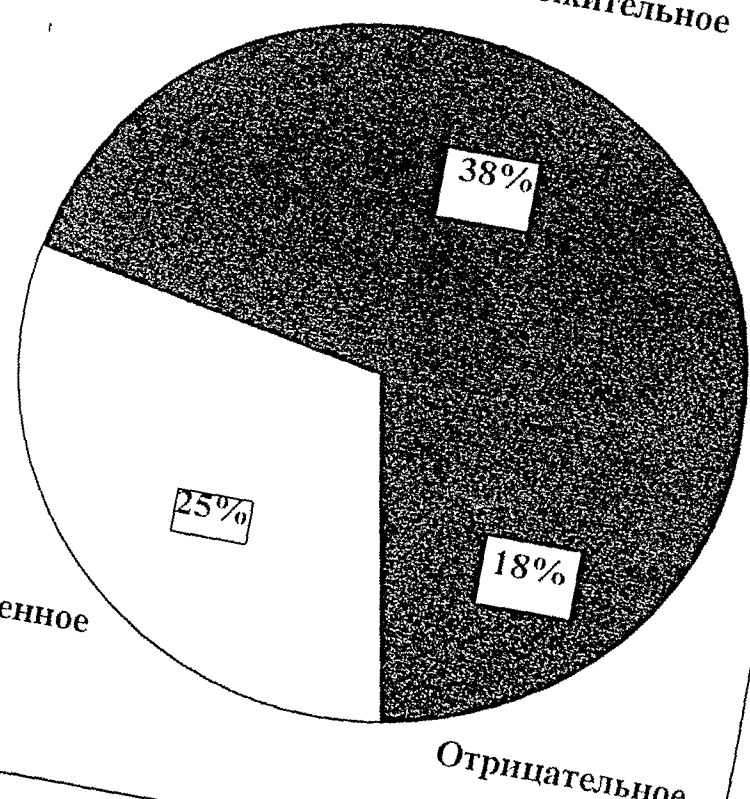
- Регион Урала/Сибири и Дальнего Востока
- Города с населением менее 10,000 человек
- 18-34 лет
- Женщины не старше 45 лет
- Респонденты, имеющие детей
- Высшее или среднее спец. образование
- Рабочие-"служащие"
- Те, кто полагают, что проблемы здравоохранения коренятся в самой системе и не являются временными
- Те, кто пользовался платн. или беспл. медициной за посл. 2 года

Системы реформирования

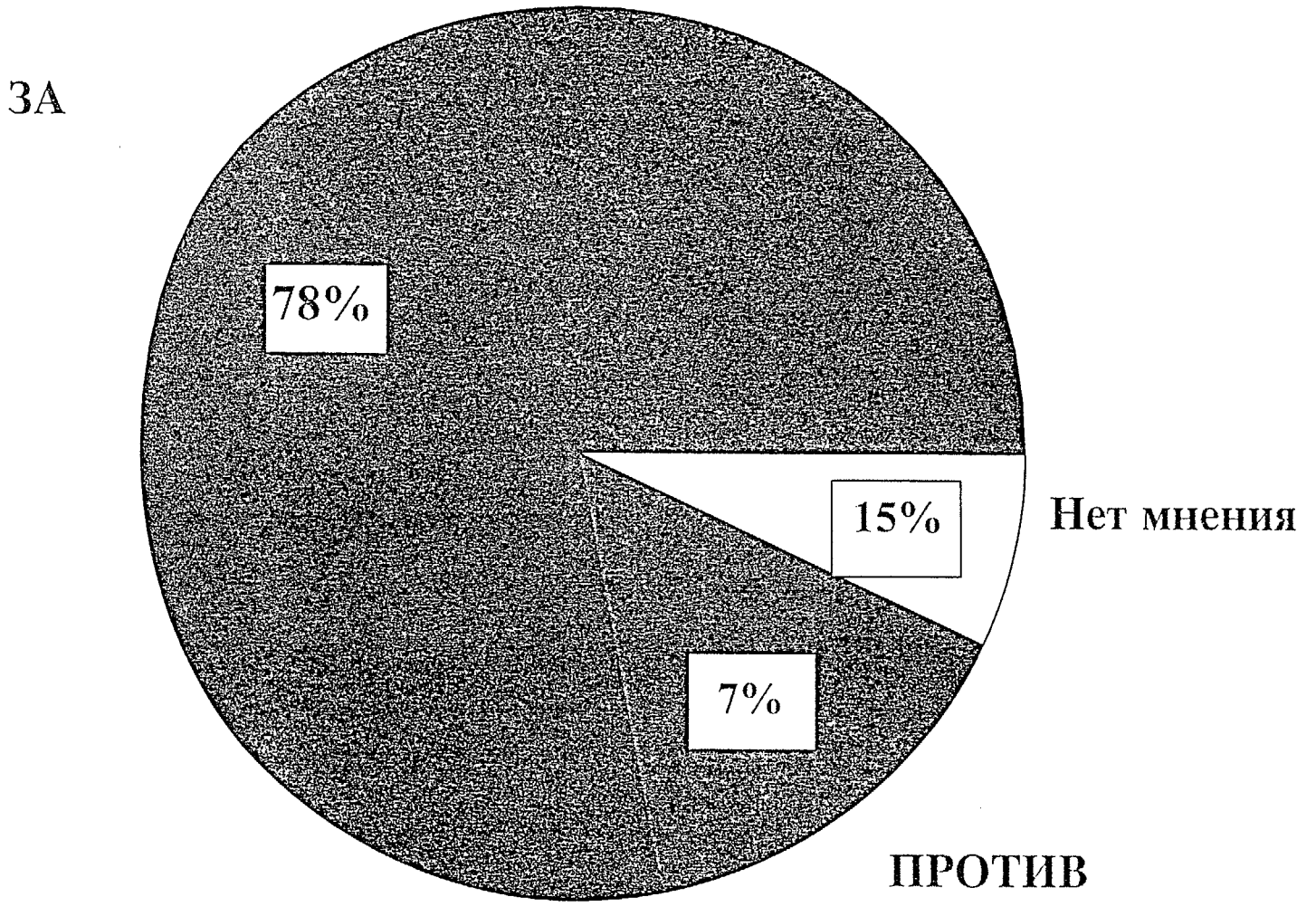
Правительство направляет ассигнования в страховые компании



Влияние на медицинское учреждение



Система здравоохранения, предполагающая развитие "доверительных обществ"



КАМПАНИЯ ОБЩЕСТВЕННОГО ПРОСВЕЩЕНИЯ

- ОРИЕНТАЦИЯ НА БУДУЩЕЕ
- ОСОБОЕ ВНИМАНИЕ УДЕЛИТЬ ВОЗМОЖНОСТИ ВЫБОРА
- СТИМУЛИРОВАТЬ КОНКУРЕНЦИЮ В МЕДИЦИНСКОМ СООБЩЕСТВЕ
- УКРЕПЛЯТЬ КОНЦЕПЦИЮ ВСЕОБЩЕГО БЕСПЛАТНОГО МЕДИЦИНСКОГО ОБСЛУЖИВАНИЯ
- ОПРЕДЕЛИТЬ СПИСОК БЕСПЛАТНЫХ/ПЛАТНЫХ МЕДИЦИНСКИХ УСЛУГ
- НАПРАВИТЬ КАМПАНИЮ НА ПОЛИКЛИНИКИ И ПРОСВЕЩЕНИЕ ПО ВОПРОСАМ ПРОФИЛАКТИКИ

MEDIA ANALYSIS OF ARTICLES COMPILED BY IPCC MOSCOW

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SECTION I
CURRENT STATUS OF HEALTH CARE SYSTEM IN RUSSIA, VOLUMES 2,3,4,5

1.1 Summary

As chronicled in the nation's newspapers, the health care system in Russia is far from impressive. Many articles have been written about the spread of disease. Another recurrent theme in these articles is the effect of the health care crisis on the demographics of Russia. Journalists tend to concentrate on specific health indicators to judge the effectiveness of the health care system. They tend to rely upon the incidence of disease and rates of birth and mortality as the final arbiters of the quality of the health care system. The effect is sobering. Infrequent references to international conferences or specific aid programs cannot dispel the sense of impending disaster to which the all too frequent recurrence of words such as epidemic and crisis give rise. Stories on incidences of hepatitis, scabies, syphilis, tuberculosis, rabies, diphtheria and AIDS are commonplace while the declining birth rate and rising mortality rate seem a constant cause for concern. As might be expected the unfortunate plight of Russian children is particularly highlighted in many articles and stories. On a similarly disturbing note, a marked and widespread absence of optimism for the future of the health care system is apparent.

1.2 Incidences of Disease and Infection:

#623 (Narodnaya Gazeta No.247, 1993, 12.24)

THE EPIDEMIC OF DYSENTERY CONTINUES IN THE VILLAGE OF STROYGORODOK

The number of victims has already reached 273. The cause of the epidemic has been discovered to be fecal matter in the supply of drinking water. At present the village apartments are relying upon boiled water. The supply has been chlorinated three times using in total nearly a ton of monochloride.

The source of the fecal matter has not yet been discovered or isolated.

#695 (Nizavisimaya Gazeta No.17, 1994, 01.28)

FROM DECEMBER 28 TO JANUARY 21 IN THE TERRITORY OF THE SARATOV OBLAST 74 CASES OF DIPHTHERIA WERE REGISTERED INCLUDING 18 CHILDREN

According to information received on January 23, 6 children have died from diptheria.

612

#705 (ITAR-TASS, 1994, 02.04)

ACCORDING TO HEALTH CARE OFFICIALS IN EKATERINBURG IN 1993 THE INCIDENCES OF DISEASES GREW BY 1.3 TIMES FOR TUBERCULOSIS, BY 6 TIMES FOR DIPHTHERIA, BY 3 TIMES FOR SYPHILIS, BY 2.5 TIMES FOR TICK BORNE ENCEPHALITIS AND BY 1.3 TIMES FOR SEROUS HEPATITIS

Medical experts have discovered a social origin for these infections: enterprises have ceased virtually all medical assistance while private companies have never offered such services. Hepatitis has grown in connection with the drastic decrease in the quality of drinking water. Medical personnel have developed a program to fight socially dangerous infections, however they believe that the increased incidences of these diseases will continue as it would require ten billion roubles to eliminate the causes of these diseases.

#959 (Sevodniya N75, 1994, 04.22)

IN THE LAST 12 MONTHS IN ST. PETERSBURG DEATHS FROM TUBERCULOSIS HAVE NEARLY DOUBLED

Until the end of 1994 the rate of incidence of tuberculosis is expected to grow steadily. The chief doctor of the city tuberculosis clinic Vladimir Zaytzev announced that the sudden growth of this terrible lung disease was caused by increased migration to St. Petersburg from former southern republics of the USSR which have very unfavorable conditions from a medical point of view. Many of these emigrants are afraid of X-rays which aid in early diagnosis and come from socially defenseless stratum of society. Since the beginning of the year there have been 611 cases of diphtheria which is 70% more than there were in one quarter of the previous year. For 20 patients the disease resulted in death. All of those who died from the disease, which included children, were not vaccinated against the disease.

#755 (Kuranty No.31, 1994, 02.17)

ONLY ONE OUT OF EVERY FOUR MOSCOW SCHOOL CHILDREN ARE FULLY HEALTHY UPON GRADUATION

According to data from the Academy of Medical Science published in the journal "Medical News", the students studies most often suffered from allergies, however there was also a high incidence of psychological disorders: among young children nearly 15%, while among teenagers 20-25%.

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1.3 Effect of Health upon Demographics:

#702 (Izvestiya No. 20, 1994, 02.02)

ACCORDING TO OFFICIAL DATA PRESENTED IN A NATIONAL SPEECH ON THE SITUATION OF CHILDREN, IN THE PAST YEAR 1,362,000 CHILDREN WERE BORN, TWO TIMES FEWER THAN WERE BORN IN 1987.

In 1993 number of deaths surpassed the number of births by nearly 805,000. In sixty-nine territories a negative rate of population growth has already been registered. The birth rate in Russia last year fell below the critical point to become one of the lowest in the world at 9.2 per 10,000 persons while the mortality rate, conversely, increased from 10.5 per 10,000 in 1987 to 14.6 per 10,000 last year. This has given specialists reason to assert that after 20 years the discussion will turn to the demographic legacy of today's reforms and the ability of a diminished population to sustain pensioners.

A world-wide health care organization has arrived at several criteria for the evaluation of the status of health and welfare of nations. One of the fundamental criteria is infant mortality. At the beginning of the 1970's in Russia this indicator was comparable to levels in the USA, Great Britain, West Germany and had even begun to decrease noticeably. However, since 1990 (17 deaths per 1,000 births) the mortality rate has again begun to grow and last year the rate increased to 19 per 1,000. The reasons are as follows: hypoxia, brain hemorrhage, congenital developmental anomalies, and intrauterine infections. In order to clearly illustrate the losses which society incurs as a result of infant mortality, the number of unlived years was calculated. In 1992 the total was nearly 500,000. The rate of mortality among children from age one to fourteen is also rising. The primary factors are traumas and unfortunate accidents, the decrease in the availability of high-quality health care for chronic and serious childhood diseases, excessive cost of drugs and the introduction of fees for many types of medical care.

The most direct influence on demographic statistics are factors such as the maternal mortality rate which is 15-20 times higher than that in developed nations. The reasons are: illegal abortions, hemorrhaging and toxicoses. According to expert evaluations 60% of deaths among women are preventable. In connection with this, we stand as the record-holders for the number of abortions. According to official statistics there are 3.5 million abortions every year, and noone knows the actual figure.

Many of the mentioned factors were presented at the Russian assembly for "Protection of the Health of Mothers and Children" organized by the Commission for Women, Families and Demographics under the President and the International Fund for the Protection of the Health of Women and Children which was recently held in Moscow.

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Nearly 3 dozen different programs in this sphere have already been developed, however they are struggling to achieve the necessary resources and basic coordination. Revisions and clear funding directed toward the most critical areas is desperately needed.

#594 (Nizavisimaya Gazeta No.242, 1993, 12.17)

BY THE END OF THE CENTURY IN RUSSIA THERE WILL BE VIRTUALLY NO HEALTHY PEOPLE

This discomfiting conclusion was reached by the authors of the monograph "The Effects of Ecological Conditions on the Health of Population of Russia" which was just published in Moscow. They establish that without exception the rise in mortality from severe respiratory and intestinal infections, congenital anomalies, colitis, leukemia and other diseases is causally connected with the worsening of ecological conditions. More than three million people breathe poisoned air. Every second Russian drinks water which does not meet required standards for sanitation.

1.4 Policy, Reform and Foreign Influence:

#733 (Nizavisimaya Gazeta No.27, 1994, 02.11)

AS DISCOVERED BY "NG" FROM SOURCES IN THE RUSSIAN MINISTRY OF HEALTH THE GRANTING OF LICENSES FOR THE IMPORT OF DRUGS TO RUSSIA HAS BEEN HALTED

In fact this constitutes the freezing at customs of many containers of crucial preparations (many of which require special storage conditions). These containers are accumulating fines and inevitably bringing about the rupturing of business contacts with foreign partners.

#824 (Narodnaya Gazeta No.43, 1994, 03.04)

THE GOAL OF ANY REFORM IS IMPROVEMENT IN RESULTS ACCORDING TO THE HEAD OF THE RAMEN ADMINISTRATIVE RAYON, V.F. DEMIN

In a cost breakdown the amount of expenditures for industrial production in 1993 constituted nearly 130 billion roubles. This figure is grave, however, as accounting for inflation this is 12% lower than the previous year. There are today 650 doctors and nearly 2,000 intermediate medical personnel working in the health care system of the region. In recent years a children's hospital, the Central Ramen Hospital Birth Center, the Nikitski and Chulkov

Hospitals, the system of out-patient clinics, and tuberculosis sanatoriums have been renovated. For the citizens an ultra-sound diagnostic department in the Central Ramen Children's Hospital. A

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program is being developed for a computer center which would allow for the automization of the investigation of disease histories. Doctors and specialists continually investigate the quality of food products.

#990 (PF, 1994, 05.13)

THE NUMBER OF FEDERAL HEALTH CARE PROGRAMS IS EXPECTED TO BE CURTAILED

As discovered by PostFactum on May 13 from official sources within the security department of the Russian Federation, specialists from an interdepartmental commission for the safeguarding of public health consider it necessary to adopt a series of laws in this area. These would include laws concerning the health care system, medicinal resources and the rights of patients.

Also, it is necessary to define which issues concerning the safeguarding of health care must be decided on the federal level and which on a regional level. At the last meeting of the commission the opinion was put forward that all programs connected with health care must be administered by the government. On the other hand in a private conversation with a correspondent from PF one of the members of the security department noted that this constitutes a backpedaling approach: the number of federal programs in connection with the latest presidential decree concerning the regularization of documentation preparation within federal programs will apparently decrease. For the regions this will mean more opportunities and freedom. For example, the production of vaccines and serums will be accomplished by the federal government, but distribution and organization will be the responsibility of the regions.

#876 (Moskovskaya Pravda No.54, 1994, 03.22)

THE FIRST GERMAN-RUSSIAN CONGRESS FOR REHABILITATIVE MEDICINE TOOK PLACE ON MARCH 19 AND 20 AT THE BALTSCHUG HOTEL

The organizers of the conference were the International Fund for Charity and Health and the philanthropic society "CARE Germany". The participants in the Congress discussed a program to introduce the German system of rehabilitation to Moscow and Russian clinics.

1.5 Conclusion

These specifics paint a grim picture of universal decline in the health care sector. The references to international conferences and reform hardly succeed in counterbalancing the reality which the media and by extension the people of Russia are all too willing to face head-on. Rates of disease and the baseline facts of illness and health are the issues that matter to the people. Reforms and policies are shown to be important only insofar as they can be shown to directly affect the reality of the health

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crisis. In addition there is seemingly no clear distinction among Russians between economic and social hardships and the health care crisis. Each contributes to the other. Ecological conditions and matters directly related to societal decay are presented again and again as the root cause of the health problems within Russia. Health care is viewed as one of the many aspects of society that is in crisis due to a general breakdown of the nation's governmental and social systems.

The problems are openly acknowledged and addressed, however, the articles invariably stop short of proposing remedies or pointing to a brighter tomorrow. If they present an accurate portrayal of the current status of the health care system in Russia, the Russian people are under no illusions as to the need for real improvement in the general health of the population.

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SECTION II
MEDICAL SERVICES IN RUSSIA, VOLUME 6

2.1 Summary

As shown from articles dating from January to June 1994, it is impossible to paint any one general picture of medical services available in Russia. Some articles, far from deriding the types of services available, have a tendency to focus on the positive, the new, the interesting-it is as if such articles are collectively saying that despite problems, innovative progress is alive and well in Russia's health care sector. Some other articles, which outline visits by government officials to medical institutions or new programs, are a bit more subdued in tone, as if merely chronologically recording events and nothing else. Paradoxically, other sources focus on key problems such as insufficient financing for the purchasing of medicines and equipment. While these articles also carry a dramatic tone about them, the emphasis is more on gaping lacks in the system and how providers are managing despite such lacks. The most curious group of sources are those which write about the new types of faith healers, promotional events, or special new services- some from a negative or objective view, many others from a rather positive point of view. The existence of such articles likely demonstrates: 1) a real dissatisfaction among the Russian consumer population with traditional medical services, 2) the continuance of old cultural beliefs and superstitions. Finally, while all the sources may detail the implementation of a new treatment for cancer or the reorganization of a hospital, the activities or faults of a popular faith healer, promotions of a new medical facility, etc., there is a striking absence of basic, accurate, comprehensive consumer information type articles on type and cost of medical services across Russia.

2.2 Focus on Positive Factors in the Russian Medical Services Sector

#235 (Moskovskya Pravda N10, 1994, 01.18)

AN ELITE POLYCLINIC OF THE 3RD ADMINISTRATION WHICH UNTIL RECENTLY SERVED A SELECTED FEW HAS OPENED ITS DOORS FOR EVERYONE

58 Doctors and 120 medical staff members, many of which are specialists with the highest grade scientific credentials, are prepared to deliver almost any type of medical care. Everyday some 25 specialists receive patients. In all, the polyclinic has 10 departments. "The polyclinic is one of the first in the city to receive a medical insurance license and it can offer paid services to organizations and individuals," said the head physician, Oleg Kuzovlev. "Polyclinic care without dental care costs $200 dollars per year, with dental care $250, with dental care plus home visits-$350. Of course payment will be in the ruble equivalent. In the words of the head physician, the prices are not expensive, if compared with analogous services offered at the former 4th Administration Hospital.

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240 (Rabochaya Tribuna N 13, 1994, 01.22)

THE HEAD OF THE SURGICAL DEPARTMENT AT THE NOVISIBIRSK MEDICAL INSTITUTE, PRESIDENT OF THE STOCK COMPANY "SIBANGIOKOR," PROFESSOR GREGOGRY MISH HAS SUGGESTED A NEW TREATMENT FOR CIRRHOSIS OF THE LIVER

The procedure, which is hard to call an operation, is fairly simple. An IV unit is hooked to the vein, feeding it medicine. Then a vacuum method sucks out the bile and filters it through an original sorbent, developed at Catalysis Institute SO RAN under the direction of academician Cryill Zamaraeva. The cleansed bile is then returned to the organism of the patient. After this a special circuit of medications is used to stimulate the working of the patient's immune system. After 25-30 days the patient leaves, practically speaking in healthy clinical condition. An analogous method can be used to treat heavy, chronic hepatitis.

Already tens of patients have been treated using this new procedure. In almost 70% of the cases, treatment was successful. In terms of modern day clinical treatment, this is a relatively high percentage.

#252 (Delovoy Mir N24, 1994, 02.05)

SICKNESS CAN BE SHOT AT FROM A CANNON (A UNIQUE MEDICAL PROJECT)

At the Oncological Center of the Russian Academy of Medical Scientists, arrive individuals with critical conditions from all corners of the NIS. It is here within the walls of this academic institute, that a new instrument comes to face the disease-a laser.

Ray treatment has been used in the treatment of cancer for a long time. The problem is that the atomic particles are too light. Entering the organism, they fly off in various directions, striking healthy organs along with sick ones. Now an experiment is taking place, whereby cancer is treated with heavy particles (protons). According to specialists, this is the single type of laser radiation, which will concentrate itself on the millimeter of living tissue that it needs to.

The development of this project along with the building of appropriate equipment is being financed by the Russian Ministry of Health and the Moscow city government. On the edge of the city, a construction site has been determined. But investors are essential. Some Russian firms have already volunteered to take part in the realization of this project.

#336 (Rossiskaya Gazeta N157, 1994, 03.26)

TECHNOLOGY LINKED WITH THE CREATION OF SO CALLED "CLEAN ROOMS" FOR

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THE PRODUCTION OF VACCINES AND OTHER PARTICULARLY PURE MEDICAL PREPARATIONS IS A HIGH-TECH FIELD THROUGHOUT THE WORLD AND IS KEPT SECRET.

Russian Scientists from the Institute of Immunology, have for the first time in domestic history created a whole block of so called "clean rooms." They are designed for the production of vaccines and other specially refined commercial medical preparations. "Clean Rooms" can also be used for the production of radioelectronic components. In comparison with analogous types of facilities, the "clean rooms" at the institute have a row of advantages. They have been constructed only on a base of domestic equipment. They can be constructed in practically any area, as long as it has a ceiling height of no less than 3 meters. Various combinations can be brought out of the clean rooms, depending on the demands of industry. Surrounding personnel are reliably protected. "Clean rooms" are already in successful use at the institute.

2.3 Basic Recording of Events.

#319 (PF, 1994, 03, 16)

DRAFT AGREEMENT ON BENEFITS TO VETERANS AND INVALIDS IN ALL CIS STATES PREPARED

On the 16th of March the Ministry of Cooperative Relations of the Russian Federation released an announcement in which it was noted that the notice for the planned Mid-April meeting of head CIS representatives, will include a multilateral agreement on the mutual bringing up of benefits and guaranties for veterans and invalids of the Second World War, participants in foreign wars, families of deceased military personnel. In the draft agreement are systematically included acts of the former USSR pertaining to benefits and guaranties for war veterans and their families. In the opinion of experts, it would be advisable to have analogous acts passed by all CIS states.

2.4 The Uphill Struggle with Key Problems.

#280 (Efir-Digest, 1994, 02.24)

OPEN RADIO (MOSCOW): THE MOSCOW RESEARCH INSTITUTE OF TRANSPLANTATION AND ARTIFICIAL ORGANS WILL NOT BE ABLE TO CONDUCT KIDNEY TRANSPLANTS THIS YEAR, BECAUSE THE HEALTH MINISTRY HAS NOT ALLOCATED ADEQUATE FUNDING FOR THE PURCHASING OF THE MEDICINE NECESSARY FOR POST OPERATIVE PROCEDURES

One small bottle of the medicine, Ciclosparina, costs $200-250 dollars. The institute needs a minimum of no less than 400 bottles of this medicine per month. The Health Ministry has allocated

funds for the purchasing of a thousand bottles per year. This is such a small amount, that the conducting of a kidney transplant becomes meaningless.

In the meantime, one such operation increases the lifespan of a patient by 5 years. Recently the singular way of acquiring funds for the buying of such an important medicine, has been through paid operations, which the institute has conducted on foreigners. In February, such operations already cost upwards of tens of millions of roubles.

#326 (Moskovskie Novosti N11, 1994,03.20)

IN MOSCOW THERE IS A LACK OF DONOR BLOOD

The other day, the capital's Red Cross urgently called up Muscovites to take part in a blood donor drive, organized at various enterprises. The cost of 100 ml of blood- 3 thousand roubles. In general, procedures for the taking of blood are identical. Not all blood gathered is used. The methods of inspecting it- dictates of the time- have become stricter. Besides tests for syphilis, AIDS, hepatitis-B, since 1994 compulsory testing for hepatitis-C has been instituted; according to some statistics, in Russia more than 10 million people are infected with the disease.

Natural donor blood remains unique and irreplaceable. For a long time, scientists have been trying to create blood artificially. But such a compound is unlikely to be appearing anytime soon. Confirmation of this is the history related to the so called "blue blood," perftoran, created at the powerful biological center of the Russian academy of sciences more than 10 years ago. Its use saved many a veteran from the conflict with Afghanistan, but petty squabbles brought it to the point where some of the biologists were criminally charged with experiments on humans. One of the creators killed himself. . .

Of course, at that time, perftoran was far away from perfection, but its [development] was a major priority for the USSR. Today, this priority has been lost. Today as before, Doctors use long ago developed blood based serums.... They help support geodynamics and respiration, but they carry no oxygen.

2.5 Articles in Support and Against Alternative Medical Services

#270 (Moskovskaya Pravda N33, 1 994,02.18

BEWARE: ALCOHOLISM

According to the favorable reviews of patients, the office of anonymous treatment, which is headed by candidate of medical science Sergery Victorovich Kikta, is one of the best in Moscow. The hypnotic methods employed by the doctor are unique- after one session ones craving for alcohol

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sharply falls. In order to solidify the effect, a number of modern methods are used: encoding (strictly individual), new medical preparations, Eriksonian hypnosis (the doctor was trained to use this method while in the states), SIT, immunological treatment. After the course of treatment is concluded, its effect is monitored. Personal attention along with patience from the staff is guarantied to all patients. In addition, treatment against tobacco addiction is offered as well.

#278 (RIA, 1994, 02.23)

THE KHBOROVSK EXHIBITION WILL NOT ONLY FEATURE THE SALE OF INEXPENSIVE GOODS FROM JAPAN AND THE US, BUT ALSO THE MEDICAL TREATMENT OF CHILDREN

800 Foreign and 200 Russian firms will take part in the international exhibition-sale, which will take place in Khbarovsk from June 1 to August 21, of this year....

Alongside the sale, on the territory of the exhibition will be organized meetings of businessmen, consultation on the creation of joint ventures, and also the free treatment of children, applying the latest achievements of medicine....

#283 (Trud N35, 1994, 02.25)

VERKHOTURIE POLYCLINICS (SVERDLOVSK REGION) ARE NO LONGER CROWED WITH PATIENTS: ALL THE SICK WANT TO BE CURED BY GRANDMA LIDIA

During her free sessions, the healer from Kiev "treated everyone for all types of diseases." There were so many longing to be cured, that the local house of culture could not hold all of them, and those that could not get in, with tears begged to be allowed inside. The guest from the Ukraine banished devils and removed ills; because of this, blood-curdling screams of those treated echoed from the hall, some people ripping off their clothes. Some people could not stand the session and had to be taken outside for some fresh air. After the sessions, Grandma Lidia declared that in Verkhoturie there is a lot of unclean strength, because of this she became very tired? avoiding looking at people's evil eye.

#343 (Narodnaya Gazeta N60, 1994, 03.30)

VISIT AT THE ALL-RUSSIAN ONCOLOGICAL CENTER

The first specialist we talked to was Professor L. Moroz of the Research Institute of Experimental Diagnostic and Therapy. "All types of 'clever medical healers' have arisen. I don't want to doubt the possibility of some healers with rich experience and knowledge. However, an evaluation of the results of their treatment as a whole shows that unfortunately, the majority of so-called folk healers

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are nothing more than charlatans. I have worked on the treatment of cancer patients for some 40 years, but not once have I encountered anyone of them fully treated by such folk healers."

"Treating a neglected condition and 'retreating' someone having been in incompetent hands is significantly harder than treating the condition from the very beginning- and chances of success are fewer."

2.6 Conclusion

Unfortunately, while the attention of the media to the medical services field is focused on the development of new technologies, the recording of meetings, the pros and cons of faith healers, etc, there is a large gap of comprehensive consumer information oriented articles. The few articles mentioning types of facilities, services and costs seem more like advertisements than actual sources of information. The other significant point of the media analysis is the paradox between coverage of state-of-the art technical advances in care and a continual focus on alternative treatments. Another similar paradox just as significant relates to their being articles about superlative new treatments and state of the art institutions along with articles which describe the lack of essential medicines. This presence of first world along with the third makes it near to impossible to herd the types of medical services in Russia under one roof.

SECTION III
HEALTH INSURANCE, VOLUME 7

3.1 Summary

As a whole, media coverage on the new health insurance system can be divided into two types: 1) positive views of the system and 2) focus on the difficult problems the system is having. Of the former, most sources date from the earlier to mid parts of 1993, when much of Russia's new health insurance system was still at the theoretical planning stages. Many of these sources are either interviews with administrators of the federal or local territorial insurance funds, or with the heads of insurance companies. Such articles tend to say in effect that while, some minor problems in implementation may remain, a powerful new system for the financing and organization of care is on its way, benefiting all concerned parties. Some articles do give a fairly comprehensive background of the new health insurance system, however others seem to be functioning more as advertisements or self-promotion campaigns for the individuals running it.

The second group of sources cast a much more sober outlook on the system, describing the very real problems in implementation, organization, and financing that the system is having. Often what is said in these sources directly contradicts the rosy predictions of the first group. Chronologically, most such articles date from late '93 or through the first part of 1994, a time when the first real results of the health insurance system became evident. The general conclusion ultimately reached by the reader is that while the theory of health insurance is a good one, real problems in organization and financing remain to be overcome if the goal of a quality health insurance system for the people of Russia is to be realized.

3.2 Positive Views and Promotion

#74 (Kuranti, N 128, 1993, 07.09)

INTERVIEW WITH THE HEAD OF THE WORKING GROUP FOR THE INTRODUCTION OF HEALTH INSURANCE IN MOSCOW, DEPUTY CHAIRMAN OF THE STANDING COMMISSION FOR HEALTH CARE OF THE MOSCOW CITY COUNCIL IGOR TIJPAKOV

The compulsory insurance system consists of funds mandatorily contributed to by each employer in the form of 3.6% of the sum of employee salaries of such an enterprise, institution, or organization, irrespective of the form of ownership. Those not working-pensioners, invalids, housewives, children will have insurance monies paid into the fund by the state.

The municipal health insurance fund will finance on a competitive basis various insurance companies, each one of which will conclude an agreement with a given number of provider

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institutions....

The main purpose of the fund is so that the doctor will be interested in the patient. An insurance company will now pay medical personnel for their work based on the level and quality of care. Patients with complaints will now address not the hospital administration, but their insurance company, which will guarantee them optimal care.

#99 (Delovoy Mir N173, 1993, 09.11)

THE IVASTROVAZ JOINT STOCK INSURANCE SOCIETY ELABORATES SEVERAL COMPREHENSIVE MEDICAL PROGRAMS FOR CHILDREN AND ADULTS

Among the share holders of the stock company "Ivastrovaz" include the powerful textile companies "Fatekc," "Tefa," "8th of March," Stock Company "Ivanovokhimprom," and others.

Complex of worked out programs including "Family Care," "Dental Care of all levels," "Rehabilitation," "Curative Cosmetology," "Voice," "Safe Childbirth," "Family Planning," and many others. Bases for treatment include. . . the leading centers of the capital.

#121 (Rossiskaya Gazeta N200, 1993, 10.27)

AN ALL RUSSIAN CONFERENCE ON THE INTRODUCTION OF OBLIGATORY HEALTH INSURANCE OPENED ON OCTOBER 26 IN MOSCOW

The law was passed only in 1991, but it has started to work only now, when finally the appropriate regulations have been drawn up for the creation of a federal fund of compulsory medical insurance. This means a new era for our health care system. Market conditions will enter [the health care field]. However, paradoxically speaking, it will be these very conditions that will act as a guarantor by the compulsory insurance fund for the least affluent classes....

Each organization, including commercial structures, will in mandatory fashion transfer to the territorial funds, which will be created across all regions of the Russian Federation, 3.6% of the sum of their employee salaries. Then their will be a second transfer of the funds, by a good equalizing principle, to the young and old members of the non-working population.

We have the right to choose our own doctor and medical institution, which will have already gone through a licensing process for the receiving of a special certificate. Where we go, the money will follow. This process, in the opinion of the Minister of Health Edward Hechaeva, will force medical institutions to run a competitive struggle for patients: widening their spectrum of services and increasing the quality of services offered.

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#144 (Moskovskaya Pravda N226, 1993, 11.23)

INTERVIEW WITH THE CHAIR OF THE BOARD OF THE FEDERAL FUND FOR OBLIGATORY MEDICAL INSURANCE, DEPUTY RUSSIAN HEALTH MINISTER VLADIMIR STARODUBOV

"They say that medical personnel are not especially enthusiastic about the Compulsory Insurance Fund. Why?"

"I think that this opinion is mistaken. Under the conditions of compulsory medical insurance there will appear the opportunity to begin to earn money. A qualified doctor should receive a lot. Not to welcome this is impossible, especially given the fact that pay of medical personnel is the 3rd lowest in Russia. In other countries, doctors are among the top 5.... . . . As a result of such reorganization, the number of polyclinic doctors will increase, while the number of patients addressing each individual doctor will decrease. . ."

#145 (Moskovskaya Pravda N226, 1993, 11.23)

INTERVIEW WITH GURAM MZHAVANADZE, GENERAL DIRECTOR OF THE GAREMED JOINT STOCK SOCIETY, PRESIDENT OF THE RUSSIAN ASSOCIATION OF MEDICAL INSURANCE ORGANIZATIONS AND A MEMBER OF THE BOARD OF THE FEDERAL COMPULSORY HEALTH INSURANCE FUND

In the field of health insurance we will work without any commercial interest, because the law forbids us to add any commercial charges to our compulsory health insurance policy. Also we are forbidden to use compulsory health insurance funds for purposes other than originally intended.....

Insurance companies will compensate provider institutions which have rendered patient services. Moreover they will compensate with funds obtained from the compulsory insurance fund. Of itself, this is not a complex procedure. Of course, at the start some difficulties in the implementation process need to be worked out. Nevertheless, already today one can say with confidence delays in payments to medical provider institutions won't take place. The system is sound from a financial point of view....

Besides quality control, we will regulate all complaints coming from the consumer population. In the structure of our insurance society, "Garmed," we have foreseen the creation of experts for both fields.

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3.3 The Real Problems Faced with the Development of Health Insurance In Russia

130 (Kommersant-Daily N218, 1993, 11.12)

In the words of Anatoly Sobchak (mayor of St. Petersburg) [compulsory medical insurance] could have been realized in the summer, however the process was hindered by some deputies from the St. Petersburg city council, entering the board of the territorial insurance fund, hardly qualified and strongly halting its progress....

But it appears that the deputies are not the only ones to blame. Over the past few months the Central Bank of Russia in conjunction with the health insurance law, monthly collected from St. Petersburg enterprises. . . 3.4% of the sum of their employee salaries. This money (20 billion roubles), was supposed to become the foundation of the territorial insurance fund, however due to various reasons the whole sum timed out to be frozen within the accounts of the central bank.

#142(Moskovskya Pravda N226, 1993, 11.23)

INTERVIEW WITH THE EXECUTIVE DIRECTOR OF THE COMPULSORY FEDERAL HEALTH INSURANCE FUND, VLADIMIR GRISHIN

"Vladimir Vadimovich, from your announcement its clear, that if the compulsory health insurance fund does not receive additional financial resources, then in no due time after the complete transfer to compulsory health insurance, there will be no funds with which to pay polyclinics and hospitals for treatment of the consumer population; in other words, a stopping of the financing of medical institutions?"

"The situation is complicated. On the one hand, its obvious, that the normative fund transfer of 3.6% for the financing of the compulsory insurance fund is inadequate, it needs to be increased. On the other hand, we understand that enterprises are already on their last legs in terms of paying taxes. So, when addressing the government, we do not ask it to increase the funds going to the insurance fund, but instead ask it to find additional resources from the 39% taken for the social tax fund."

#155 (Kommersant-Daily N249, 1993, 12.25)

MOSCOW WILL INTRODUCE COMPULSORY MEDICAL INSURANCE ON JANUARY 1, 1994, SAYS HEAD OF THE MOSCOW CITY HEALTH DEPARTMENT ANATOLY LOVYEV

However, one major factor blackens the (otherwise pretty picture of health insurance based medicine). . . (It seems that under a system of compulsory health insurance, when a medical institution) has a monopoly for many types of treatment, it then does not have to compete for clients. This leads to the quality of medical services remaining at the prior low level, and often an insurance

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company either cannot or does not want to investigate complaints of treatment made by its clients.

181 (Radio "Novosti," St. Petersburg, 1994, 02.16)

Hopes placed on additional financing due to the insurance payments by the major enterprises of the city have not proved themselves believable....

As a result of major expenditures and general inflation, medical organizations have started to accumulate debts, having money only for the payment of personnel. Questions relating to the legal base of the new (insurance) system have remained unanswered.

#202 (Kuznetsky Rabochy N50, Novokuznetsk, 1994, 04.02)

THE TERRITORIAL HEALTH INSURANCE FUND HAS SUGGESTED THAT INSURANCE WARN MEDICAL INSTITUTIONS THAT THEIR IS A LACK OF MONEY COMING IN FROM SOME ENTERPRISES

Miners. . . and workers of the Novokuznetsky Aviation Plant will only be provided with emergency care. . . The debt of the Aviation Plant to the insurance fund has become chronic: For 15 months the fund has not received one kopeck of funding (from the plant).

#216 (PF, 1994, 05.04)

THE ADMINISTRATION OF THE KUZBASS HAS TAKEN MEASURES SO THAT HEALTH INSURANCE FUNDS ARE DISTRIBUTED AS INTENDED

. . .As shown by the experience of last year, many local administrations have transferred money not to the fund, but directly to medical institutions, which do not at all spend it as intended.

#220 (Rossiskaya Gazeta N86, 1994, 05.07)

ALL MEDICAL INSURANCE COMPANIES IN THE STAVROPOL REGION, WHICH WAS THE FIRST REGION IN RUSSIA TO INTRODUCE HEALTH INSURANCE BASED MEDICINE ARE GROWING RICHER, MEANWHILE MEDICAL ESTABLISHMENTS ARE GROWING POOR

. . . pay for doctors carrying individual responsibility for the diagnoses and treatment of patients, is many times lower than, what the personnel of insurance companies earn, which do not directly treat anybody, but only enforce the carrying out of medical diagnoses and treatment.

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3.4 Conclusion

According to the various sources sighted, while many administrators of territorial insurance funds or insurance companies continue, for reasons both personal and political, to present a rosy view of the health insurance system, the system itself suffers from many real problems. Rather, than being a smooth and easy process, the implementation of the new insurance system has proved to be a major financial, organizational, and social headache for Russia. Nevertheless, as the sources also state the process goes forward. Rather than trying to do away with the system entirely, reformers are trying to get it to function as was originally intended. As with other media coverage, many of the articles cited seem to be either focusing on the dire problems or on the self-promotion of interested parties.

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SECTION IV
PRODUCTION AND TRADE IN MEDICAL EQUIPMENT, VOLUME 8

4.1 Summary

As presented by the print media, production of and trade in medical equipment within Russia is a dynamic industry. Numerous articles evidence a flurry of international and domestic activity concerned with supplying equipment and materials for the Russian health care market. The supply of information is also significant if international conferences and exhibitions are any indication. Clearly international companies perceive that the Russian health care system offers nearly unlimited potential for equipment modernization and supply. On the domestic front small private firms as well as enormous factories are attempting to tap into the emerging medical market. Defense firms are converting to production of medical technology and medical experts are using their expertise in the field of production. The extent of the investments and efforts is unclear. However, the apparent willingness of foreign firms to invest in the Russian health care system and Russian firms to work both on their own and in conjunction with these foreign companies surely indicates a potential for legitimate progress and improvement in the supply of medical technology and equipment.

4.2 Foreign Medical Production and Trade:

#198 (Economics and Life No.11, 1994, 03.25)

INSTRUMENTS OF HEALTH

More than 500 firms, ventures and organizations from Russia, Austria, Great Britain, Germany and other nations of the world will present their expositions at the fifth annual international exhibition "Medtechnica - 94" which is opening in Moscow on March 21 on the territory of the exhibition complex at Krasnaya Presnya. The exhibition was organized by the trade organization "Expocenter." This exhibition is the most important of the program of Moscow exhibitions for the past year in that health care in Russia is at a stage of reorganization and is in need of a wide array of medical technology.

#174 (Rossiskaya Vesti No.26, 1994, 02.15)

THE HEAD OF THE MOSCOW OFFICE OF THE GERMAN CONCERN "SIEMENS AG", ROBERT SCHMIDT: "WE ARE SEEKING AND FINDING RELIABLE PARTNERS IN RUSSIA"

Our fiscal year does not coincide with the calendar year. It begins on October 1 and runs through

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September 30. In this period for 1992-1993 we have received a portfolio of orders in Russia worth 500 million German marks. In the past year this has reached one billion marks. The medical technology department of our firm is leading our activities in Russia. Presently it has representatives in Vladivostock, Irkutsk, Kemerov and Ekaterinburg. Three quarters of our transactions are connected with the medical sector. These transactions are not entered into in Moscow, but instead outside of Moscow in the rural regions.

What can we offer to the Russian medical system? Various equipment and apparatus necessary for doctors and patients. For example, tomography. This type of technology is rather expensive. Siemens has offered to the Russian market high quality computerized tomography at a relatively low price.

Siemens is involved in areas such as medical technology and automization, complex administrative systems, energy, and telecommunications and information.

#155 (Moskovski Komsomolets No.7, 1994, 01.13)

MOSCOW HOSPITALS TO BE OUTFITTED WITH AMERICAN EQUIPMENT

137 million US dollars worth of medical equipment will be purchased for Moscow institutions. As indicated by the Ministry of Health of the Russian Federation, approximately twelve million dollars will be spent on US equipment for the production of blood substitutes in polymer bags and a technological system to bottle insulin. In the State Institute of Blood Substitutes and Medical Preparations substances crucial for the treatment of diabetics will be produced. In addition it will produce packaged blood substitutes which are necessary for operations.

Sixty five million dollars will go towards the purchase of equipment to outfit the NII Bakuleva Neurosurgical Complex while sixty million dollars will go to the Bakuleva Cardiovascular Surgery Institute.

The funds are being supplied through an American investment credit which must be reimbursed within five years.

4.3 Russian Medical Production and Trade:

#175 (Moskovskaya Pravda No.32, 1994,02.17)

SPECIALISTS AT THE MECHANICAL FACTORY HOLDING CONCERN "LENINETS" HAVE DEVELOPED A NEW TYPE OF ELECTROCARDIOGRAPH EQUIPPED WITH A PORTABLE BATTERY

New products are satisfying increasing demands on medical facilities in rural areas.

Living under the constant threat of being disconnected from the medical services network, local doctors and rural hospitals have demanded of the administration of the Leningrad Oblast that the new electrocardiographs be installed in all medical facilities. At present a contract has already been concluded with mechanical factories in St. Petersburg to place several hundred cardiographs in oblast medical facilities.

#57 (Deloviy Mir No.135, 1993, 07.20)

THE MOSCOW MACHINERY INDUSTRIAL ASSOCIATION "BANNER OF THE REVOLUTION" HAS BEGUN THE PROCESS OF PRODUCING GOODS FOR SOCIETY WHICH ARE SUITABLE FOR TECHNOLOGICAL PRODUCTION, THESE INCLUDE MANUFACTURING INSTRUMENTS NECESSARY FOR SURGICAL PROCEDURES.

#42 (Deloviy Mir No.108, 1993, 06.10)

AN ASSOCIATION OF MANUFACTURERS OF DISPOSABLE MEDICAL AND CONSUMER GOODS WILL BUILD A DISPOSABLE SYRINGE FACTORY IN THE CITY OF ENERGETIKA-ATOMSHIKA NOVOVORONESH

The factory was the idea of the former Chief Sanitation Doctor of the oblast, Yuri Korzha who is now the vice-president of the association. Over the course of ten months the production of 200 million disposable syringes per year was organized. All of the equipment was produced domestically. The process of sterilizing the syringes is wholly unique: with the help of an accelerator Harkov scientists set up the unit according to the requirements of the association. The association then built two factories in Novovoronesh - for the production of plastic plateware and stoppers for medical utensils which formerly were imported from Hungary for hard currency.

Not long ago the association constructed another disposable syringe factory in Voronesh which produces 200 million syringes each year. In this way the problem with disposable syringes has been eliminated in Russia. The associations share is 40%.

The Voronesh association has begun construction on a factory/pharmacy to produce blood substitution solutions on the order of 45 million units (one half liter packets) per year. The solutions will be prepared according to the formulas of the well-known German firm

"Fresenius." In addition the association is planning to produce 30 million systems for transfusion of these solutions as well as systems for artificial kidneys and hearts as well as one billion needles for the disposable syringes. The association will be able to guarantee the availability of these products to the entire European part of Russia.

This type of factory/pharmacy exists nowhere else in the world.

Presently computer modeling is being done in Germany. Finished designs are sent by fax and work is begun immediately. The association intends to take 2.5 years to build the factory. The new factory will also create 3,500 jobs.

The association has also found a means of financing for the construction of an insulin producing factory: the Americans have promised not to disclose the source.

Yuri Korzha hopes to build a factory to produce various surgical instruments for standard operations such as the removal of appendix, hernia surgery and caesarian deliveries.

4.4 Conclusion

The specifics of change in this sector as expressed in these articles are encouraging. While some of the progress is apparently short term and specific, the reality of significant investment in the equipment supply sector of the health care system bodes well for the future. Foreign and domestic firms are not only showing their wares and selling products, they are investing for the long term. Although such activities do not yet constitute the norm, factories are being built and supply networks are being developed. Perhaps more importantly, Russian firms appear to be recognizing that the health care industry could constitute a long term source of business for technology and equipment purchases. One issue, however, should not be overlooked and that is the question of cost. These articles clearly show that foreign equipment and even newly produced high-tech Russian equipment does not come cheap. The ability of typical health care facilities to purchase the products now offered to them remains unclear. The fact that top quality medical equipment and technology is now available to the Russian health care system must, however, be seen as a positive sign for the future.

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SECTION V
NEW PUBLIC HEALTH STRUCTURE, VOLUME 9

5.1 Summary

The Russian health-care structure is undergoing significant changes. According to the assembled articles, new facilities, procedures and approaches are being created and implemented across Russia. The nature of these changes appears to be on the whole positive, yet unstructured. The new facilities and structures are no doubt necessary, but there is no indication that they constitute part of an overall plan or will contribute to progress in the health-care sector as a whole. This is especially true with regard to financial systems. Privatization is shown to be a viable option in several areas; however, a widespread expectation of universal free health care is clearly evident. One can conclude from the articles on new health-care structures that localized specific progress is being made. Whether this progress will be sufficient to significantly affect the general provision of health care in Russia remains unclear.

5.2 Privatization and Financing:

#185 (PF_N, 1994, 04.11)

IN THE KEMEROVO OBLAST MORE THAN 100 PRIVATE FIRMS, TRADING COMPANIES AND COOPERATIVES ARE PROVIDING MEDICAL SERVICES TO THE POPULATION

According to statistics from the oblast in 1993 in the Kemerovo Oblast the medical services for the population included 212 hospital facilities with 39,500 beds, 25 ambulance and emergency stations and 40 sanitation/epidemiology stations. The medical services also include 297 ambulances and polyclinics with a general capability of 59,900 visits per working shift. The number of doctors of all specialties is 14,000 and the number of intermediate medical personnel is 37,900. There are 44 doctors, 120 intermediate medical personnel and 124 beds for every 10,000 persons.

326,000 workers and their families rest and receive treatment in 38 sanatoriums, a resort, 81 preventoriums, and local seasonal facilities.

#1 (Meditsinskaya Gazeta No.l, 1993,01.01)

THE MOSCOW MEDICAL EXCHANGE BEGINS TRADING AT SHABALOVKA

Manager of the Exchange - V.I. Beregovoy Shares on the exchange cost 100,000 roubles. Ownership of shares guarantees the right to be present at every auction without charge. Tickets for other visitors cost 100 roubles. At the auctions the following are represented: medical supplies, diagnostic

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equipment, apparatus, hospital equipment, medical instruments, disposable materials, replacement parts, bandages, reagents (in all nearly 800 types) as well as medicines, medicinal herbs, raw materials and food products (more than 300 types).

A representative of the leadership of the medical exchange Evgeni Tonik stated "Medicine has the best prospects of any capital investment. For now the exchange is not wealthy, but we, the joint venture 'Medreks' and the association 'Detstvo' as a team are helping the exchange to stand on its own. I think that it has a future."

The exchange only organizes auctions and does not participate in them. Brokers provide clients in association with the exchange office.

Address of the Moscow Medical Exchange - Shabolovka, 3

5.3 New Facilities and Programs:

#182 (Narodnaya Gazeta No.64, 1994, 04.05)

GRANDMOTHERS AND GRANDFATHERS CAN GO FOR HELP TO THE MEDICAL\SOCIAL OFFICE OF THE REGIONAL SOCIETY OF THE RED CROSS DOMODEDOVO WHICH JUST OPENED IN THE FIRST DAYS OF APRIL

Here elderly people can have their blood pressure checked, receive medicine and, if necessary, get an injury dressed or bandaged. In the future the office plans to increase the range of available medical services. Two not insignificant details: first, the office is located in the exact center of the city and getting there is very easy and second, the medical services are offered free of charge.

#172 (Deloviy Mir No.50, 1994, 03.11)

AT THE VOLZHSKI AUTOMOBILE FACTORY A CENTER FOR WORKERS' MEDICINE HAS BEEN CREATED

One of the most important assignments of the new structure of subdividing large factories is the prevention, discovery and treatment of illnesses among persons working in hazardous situations.

Medical services are moving closer to the work place in industry. The network of medical facilities is broadening. Doctors will now have regular hours for seeing patients and perform regular preventive screenings in order to provide qualified medical aid to any of the factory's workers at a convenient time.

#162 (Trud No.29, 1994, 02.17)

A CHILDREN'S REHABILITATION CENTER AND SCHOOL HAS OPENED IN PETROPAVLOSK-KAMCHATKA - ACCORDING TO SPECIALISTS IT IS THE FIRST INSTITUTION OF ITS KIND IN THE RUSSIAN PROVINCES

Among its staff are experienced pediatric doctors, doctors of psychiatric therapy, logopedics, and opthamologists. The primary specialty of the center is the correction of hearing and sight among children with hearing and sight difficulties. In addition, the center provides help for parents of children who suffer from defects in proper physical and mental development. The treatment and training of young children and teenagers is organized according to specialized programs which employ the most modern techniques in the areas of both medicine and specialized pediatrics.

#142(Moskovskaya Pravda No.253, 1993, 12.30)

IN MOSCOW A CITY CENTER FOR REPRODUCTIVE HEALTH AND FAMILY PLANNING WILL BE CONSTRUCTED ON SEVASTOPOL PROSPEKT

The building will be constructed by the Turkish firm "Enka" which built Petrovski Passazh and is currently restoring the upper floors of the White House. This specialized project will allow for separate rooms for mothers and their newborns as well as a special system of ventilation in the operating rooms. The clinic will have space for 250 beds. It will offer consultative and diagnostic services and have a department of obstetrics and gynecology as well as an extracorporeal department in which will be performed so-called test tube conception. The center will be equipped with French equipment valued at approximately five million dollars.

The leadership of the medical management team is determined that this center will provide service to all women who come to it free of charge.

5.4 Conclusion

These articles make clear that in response to a clear need for improvement in health care, attempts are being made to change the structure of health care provision in Russia. Unfortunately, it is equally clear that the changes are more quantitative than qualitative. With few exceptions the solutions are extensions of the government-controlled structures of the past. If the health care system is indeed in crisis these solution will, at best, address specific recognized needs without providing any sort of broad-based reform. True significant changes in concepts and approaches seem to constitute only a small part of the new structures emerging in the Russian health-care system. Health care is perceived as a fundamental requirement of society and the general tenor of these articles is one of progress and optimism: health care is moving forward with modern ideas and technology. This contrasts sharply with the general perception of a health-care crisis in Russia.

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SECTION VI
PHARMACEUTICAL INDUSTRY, VOLUME 10

6.1 Summary

The pharmaceutical industry is the subject of a great deal of media attention. Foreign investment and aid are highlighted as well as advances in domestic research and production. An undercurrent of concern, however, is also present. Shortages and significant cutbacks in funding are frequently cited as threats to the integrity of the pharmaceutical industry. Financial systems aimed at controlling prices and assuring access to necessary drugs are evident, yet they would appear to be only partial solutions. The industry is in a period of flux and is attempting to both spur domestic supply and production while encouraging foreign investment all in an effort to achieve a stable pharmaceutical market.

6.2 Financing and Supply of Pharmaceuticals:

#336 (Deloviy Mir No.91, 1994, 04.28)

A WIDE RANGE OF PHARMACEUTICALS IS NOW AVAILABLE AT PHARMACY COUNTERS. THE INCREASE IN QUANTITY AND ASSORTMENT HAS ALLOWED FOR AN INCREASE IN THE REORGANIZATION OF THE PHARMACEUTICAL SECTOR. THIS CAN FOLLOW THE EXAMPLE SET BY MOSCOW.

Presently almost all pharmacies have been granted legal independence, opened payment accounts and settled their balances. As a result their relationships with their suppliers have changed. Pharmacies now operate using warehouses and pharmaceutical factories as economic partners. Positive results have not been slow in coming.

At the same time many are disturbed by the high prices for drugs whose expiration dates have sometimes passed, the massive numbers of closed pharmacy counters and the level of service. Discussions have begun about turning pharmacies over to private interests and selling them at auction. It is said that in the West most of these sorts of facilities are owned privately.

A number of questions have arisen among pharmacists. The well known company "Nikomed", hoping to answer its colleagues questions, organized a seminar for pharmacists and doctors in Moscow. The role of pharmacies in the microstructure of a modern city, privatization from the point of view of doctors and pharmacists as well as medical insurance were discussed.

A presentation of the firm's new facilities was conducted - sales outlets and pharmaceutical warehouses in Moscow. The firm belongs to an international association of pharmaceutical

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companies which make up the corporation "Hafslund Nikomed" the products of which are in demand the world over. Nikomed has been working successfully with Russian partners for several years.

#319 (RIA, 1994, 03.30)

THE GOVERNMENT ALLOCATION FOR THE PURCHASE OF DRUGS HAS BEEN DECREASED AND THE SHORTAGE OF MEDICINES IS GROWING

The security of the population's drug supplies will worsen dramatically by the Fall of 1994 if the extraordinary measures are not adopted at the federal level. This prognosis was presented on March 30 by Galina Korotkova the leader of the trading organization "Pharmimeks" at the Meeting of Russian Pharmaceutical Association currently taking place in Moscow.

"Presently in Russia we have begun to receive drugs paid for through credit accounts in the World Bank and EC," Galina Korotkova told our correspondent. "As of the end of March the value of these shipments was more than 100 million dollars."

In the opinion of Ms. Korotkova these deliveries through these lines of credit makes the situation easier (in the first six months shipments of medicine worth between 250 and 300 million dollars are expected), however, they will not solve the fundamental problem.

"Since 1991," explained Ms. Korotkova, "the government apportionment for centralized purchases of pharmaceutical has been cut (from a total amount of from 2.5 to 1 billion dollars in 1992 to 500 million dollars in 1993). Official statistics regarding the allocation of funds for the current year have yet to be released, however, according to official statistics the figure will be even lower than that for the previous year. At the same time domestic drug output is falling - by 13% in 1993 - which is critical. For example only 9% of the demand for cancer drugs was met. Due to the lack of anaesthetic resources operations have been put off. Equipment for biomedical research is idle due to a lack of reagents."

"In all civilized countries there is government support for the security of the supply of pharmaceuticals. The population of Russia does not have such support," stated Ms. Korotkova, "price limits have not been set and this puts a terrible burden upon the ill. There is no organ in Russia that controls the situation; noone knows what kind of hidden problems are going to arise today in different medications or how many and what kind of pharmaceutical are coming into the country from various sources."

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6.3 Production and Development:

#320 (Nasha Gazeta No.38, Novokuznetsk, 1994, 03.31)

AN AGREEMENT HAS BEEN REACHED REGARDING INVESTMENT IN A CONVERSION PROGRAM FOR THE KUZBAS DEFENSE INDUSTRY. THE AGREEMENT WAS NEGOTIATED BETWEEN THE ADMINISTRATION OF THE KEMEROVO OBLAST AND THE FEDERAL COMMITTEE FOR DEFENSE PRODUCTION.

The agreement provides for the refitting of the Kemerovo factory "Kommunar" for the production of pharmaceuticals.

#305 (Deloviy Mir No.55, 1994, 03.17)

RUSSIAN SPECIALISTS WORKING AT THE HEADQUARTERS OF THE TRADING COMPANY "INPOLIMED" IN MOSCOW HAVE DEVELOPED A NEW MEDICAL COMPOUND "LIBEROL"

The drug has passed through clinical tests and has been authorized for application by the Ministry of Health of the Russian Federation.

The compound takes the shape of a blue, oval, polymer film which can easily be attached to gum and dissolves into the gum in 20 -30 minutes. The primary active component of Liberol is Tiroliberin: a natural brain substance.

Improving the flow of blood in the brain, the compound acts almost immediately as an anti-depressant and psychiatric stimulant. In 30 minutes mood, physical and psychological attitude, aptitude for work and attention span all improve while sluggishness, apathy and depression disappear.

#275 (Kommersant - Daily No.26, 1994, 02.15)

NEITHER HEALTH NOR MEDICINE

It seems as if, in the near future Russia may find itself without both life-sustaining medicines and a system of bio-medical science. Such a conclusion can be drawn from the announcement by the president of the Russian Academy of Medical Science, academic Valentin Pokrovskovo, in which he stated that the research program for the pharmaceutical sector for the years 1994-2004 may not be completed due to the lack of government financing.

6.4 Foreign Involvement and Investment:

#304 (BMMR, 1994, 03.17)

THE REPUBLIC PHARMACOLOGICAL UNION "PHARMATSIYA" HAS CONCLUDED A CONTRACT WITH THE AMERICAN FIRM "BRISTOL-MEYERS SQUIBB" TO BRING ITS PRODUCTS INTO THE RUSSIAN MARKET

The firm produces cardiovascular compounds which are sold in many countries.

#202 (Kommersant - Daily, No.209, 1993, 10.30)

REPRESENTATIVES OF THE GERMAN CHEMICAL-PHARMACEUTICAL CONCERN BAYER WHICH IN THE LAST CENTURY CREATED THE COMPOUND ACETYLSALICYLIC ACID AND WAS THE FIRST COMPANY TO SELL THE DRUG UNDER THE NAME "ASPIRIN" ANNOUNCED AT A PRESS CONFERENCE IN THE METROPOL HOTEL ON OCTOBER 28, 1993 THE BEGINNING OF THE PRODUCTION OF THE COMPOUND IN RUSSIA

6.5 Conclusion

The Russian pharmaceutical industry as represented in these articles has entered a chaotic period during which is willing to try anything which might lead to a stable supply and production of pharmaceuticals. From financial systems to direct imports and joint ventures, all facets of the industry are changing. Foreign investment seems to be a viable option due to the potential for profit in the pharmaceutical industry, however, as with most foreign goods and services, price remains a significant barrier. According to these articles the prices demanded by foreign imports and investments is higher than many Russians can afford. Prospects for the future appear somewhat positive due to the extent of foreign involvement and Russian determination to increase and improve production. Maintaining the safety net so important to many Russians will, however, remain a serious challenge.

SECTION VII
SPEECHES BY HEALTH OFFICIALS, VOLUME 11

7.1 Summary

If any one conclusion can be drawn from the most recent and significant speeches made by figures within the sphere of Russian health care it is this: The decline in the Russian health care system is not so much a reflection of decline within the health care system itself, as it is a decline in Russia's political, economic, social, and moral foundations. The country of Russia is going through a stressful crisis that is tearing away at all foundations of its society, health care being one among many such foundations. If the health care system in Russia is to be reformed, the society must first evolve the proper structures ranging from stress centers for adolescents to better control over inflation to far greater political stability. One thing is certain, no matter how qualified health administrators and medical personnel may be, their hands are tied if society as a whole does not heal itself of its chaotic disturbances and troubled discord.

#6 (PF, 1993, 02.11)

ACADEMICIAN ALEXEI YABLOKOV: A NEW APPROACH TOWARDS HEALTH PRIORITIES IN RUSSIA IS NEEDED

The council to the president on ecological and health protection has prepared a report for the security council of the Russian Federation, containing conclusions which will force a major change in the traditional way the nation's health problems are viewed. The new view bases itself on the decreasing of the average Russian lifespan to lower than 70 years. Figures have shown, that the major factors of premature death [in Russia] do not have to do with the quality of medical services, but with social-economic and ecological factors. The threat to national security from the worsening of the nation's health (premature death) will be more or less lessened when the social-economic causes then the ecological causes of this factor are eliminated, reforming medical institutions is the last of our priorities.

#37 (Trud N 147- 148, 1993.6.26)

INTERVIEW WITH ACADEMICIAN LEVON BADALYANA, OF THE RUSSIAN ACADEMY OF MEDICAL SCIENCES AND RUSSIAN ACADEMY OF EDUCATION

[Russia's leaders] need to be more considerate and caring about their people. The president says something, the speaker immediately takes an opposing stand, not with any less conviction. They are heard by millions of people, and many of these millions literally have their spirits split. (By the way, the word schizophrenia comes from the words "schiz"-split, and "phrenia"-spirit)

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How can one immediately put before people such demands? Who is capable of understanding what is constitutional and what is not, what is legitimate and what is not. . .

Fires need to be put out in Russia. Above all there needs to be a rise in the standard of living. A new constitution: So that a person knows that his rights cannot be taken away and that his property-even if its only his apartment-is inviolable.

#103 (Novaya Ezednevnaya Gazeta, 1993, 09.22)

INTERVIEW WITH THE CHAIRMAN OF THE CENTRAL COMMITTEE OF THE UNION OF RUSSIAN MEDICAL PERSONNEL, MIKHAIL KUZMENKO: BY THE YEAR 2000 THERE WILL BE NO HEALTHY PEOPLE IN RUSSIA.

We, union members, and our scientific colleagues have urged the president to listen about the problem of health care and medical science, placing it on the platform of national security. By the year 2000 there will be no healthy people in Russia. . .

[The federal ministry of finance] does not finance our institutions. . .

Almost all the clinics of the Academy of Medical Sciences closed for the summer. . .

In Ekaterinburg the institute of tuberculosis has closed and released all one thousand patients because there is no money for water, gas, food, treatment.

In Oblinsk the onochological center has closed. There is no money.

#152 (Kommersant-Daily N221, 1993, 11.17)

HEAD OF THE RUSSIAN ANTI-AIDS CENTER VADIM POKROVSKY COMMENTS ON THE STATEMENT BY A MOSCOW SANITARY CONTROL COMMITTEE OFFICIAL WHO SITED STATISTICS SIGNIFYING A SHARP GROWTH IN THE NUMBER OF AIDS CASES IN RUSSIA.

Preventive measures taken are all well known. . . however, the lack of public information such as the lack of publication of scientific articles, and simply lack of statistics on spread of the disease, has given rise to a false feeling of security.

And as experts have predicted, the epidemic has begun and society as before is not prepared to counter it. [The state] does not finance the program against aids. Legislation regulating the obligations of the state to suffers of AIDS, ran through the former parliament and was hung to dry. Its also doubtful how suffers of aids can in Russia's dire economic conditions depend on qualified

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care for their condition-the cost of such care being several thousand dollars.

#164 (RIA, 1993, 11.30)

PROFESSOR CHUGAEV: PENAL CAMPS ARE HOT BEDS OF TB.

#170 (RIA, 1993, 12.21)

BRAIN DRAIN OF MEDICAL SPECIALISTS FROM RUSSIA MAY HAVE CATASTROPHIC CONSEQUENCES FOR THE COUNTRY

For the past two years, some 150 medical scientists have emigrated abroad. Another 200 are working abroad on a contractual basis.... [The President of the Russian Academy of Medical Scientists, Valentin Pokrovsky] emphasized that those leaving are the scientific and medical elite, and that this significantly undermines Russia's health system. Valentin Pokrovsky observed that for the past time interest among young people in the medical profession has significantly fallen. A significant number of perspective young scientists are going to work instead for commercial structures not at all linked with medicine.

#179 (Megapolis Express, N51 1993, 12.29)

INTERVIEW WITH ALEXEI YABLOKOV, ADVISER TO THE RUSSIAN PRESIDENT ON ECOLOGICAL AND HEALTH ISSUES

Today there are fewer people dying from heart problems than from suicide. More from accidental deaths than from cancer. Death as the result of industrial accidents, transport collisions, poisoning constitutes a real threat to the nation...we are headed towards technological catastrophe. On average everyday in the country there are two gas explosions. . . Everyday there is a major railroad disaster. . .Every month a major industrial disaster, twice a deadly disaster along the ranks of the radioactive explosion at the Tomsk nuclear facility.

And we don't have a real government. We have a group of varying ministries each one defending their own interests.

#193 (Sevodnya N28, 1994, 02.12)

CHILDREN'S PRACTITIONER I. LESHKEVICH SPEAKS ABOUT CHILDREN'S HEALTH IN RUSSIA

Last year only 27% of some 62 thousand Moscow newborns were pronounced totally healthy, because as follows many pediatric diseases our obtained while still in the womb of the mother, as

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a result of many negative factors acting on her: stress, bad diet, pollution, etc. for the past two to three years there has been a dramatic growth in chronic pediatric diseases such as cancer, endocrinological diseases, including diabetes, and especially worrying is the growth of diseases of the nervous system and sense organs, of psychological disorders.

The growth of psychological disorders is influenced by many factors but most especially a child needs a normal, kind microclimate for survival, this is called a stable family. . . No one was prepared to face this dramatic growth in psychological disorders, including medical professionals.

#223 (Znamya, Kaluga, 1994, 03.11)

INTERVIEW WITH HEAD OF THE DEPARTMENT OF GYNECOLOGY OF THE KALUGA AMBULANCE SERVICE, N. V. PESHKO

For the past two years the number of operations performed has dramatically grown, especially major ones. The quantity of hemorrhaging and stillborn births has grown dramatically. There is one central cause: Among many of our patients the quality of life has greatly worsened, stresses taking a chronic character.

#238 (Komsomolskaya Pravda N49, 1994, 03.23)

INTERVIEW WITH IMMUNOPROFILAKTIKA PROGRAM DIRECTOR AA MORGUNOVA

The worsening of sanitary conditions has to do with a worsening of living conditions. Migration has greatly increased: refugees, war victims, beggars. . . they are all carries of epidemiological diseases. . .

#266 (Moskovskya Pravda N86, 1994, 05.04)

INTERVIEW WITH HEAD OF THE MOSCOW REGIONAL NORCOLOGICAL CENTER, VALENTIN GALKIN

According to studies carried out by us some 10 to 30% of the labor force needs the help of psychological/norcological support staff, psychotherapists, social workers. And members of their families need essential psycho/correctional support services. . . [over the past few years] the majority of industrial accidents have occurred because of high alcohol intoxication.

7.2 Conclusion

#23 (Moskovskya Pravda N 108, 1993, 06.09)

INTERVIEW WITH MOSCOW MEDICAL ACADEMY PROFESSOR YEVGENY YUMATOV, DIRECTOR OF THE INTERNATIONAL REGIONAL STRESS CONTROL CENTER

A serious thing has happened- our life has lost its arrangement. Disappointment in the past and hopelessness for the future. The emotional foundation of society has become negative, when in order to over come our crisis a positive outlook is needed.

SECTION VIII
PRIVATIZATION - VOLUME 12

8.1 Summary

If the sources cited is any indication, a dichotomy has occurred in Russian society over the issue of health-care privatization. On the one side, powerful, dynamic forces in industry and business are embracing the concept; on the other side, many other less affluent groups (medical professionals among them) fear that privatization is destroying the very foundations of their lives. It seems that the two groups diametrically oppose each other and will not try to understand each other's separate and mutual concerns. Fortunately, there seem to be a few voices that are less dogmatic and more practical: they are for privatization and reform as long as it is carried out rationally over time and step by step, that health structures of vital national importance remain under some kind of state control and supervision, and that the force of privatization does not oppose state structures and regulations, but cooperates with them.

8.2 Forces Moving in Favor of Privatization

#6, IPCC, vol 12, (Kommersant N33, 1993, 08.23)

AUCTION OF "STOMATOLOGIA" STOCK ENDS ON SEPTEMBER 1

The (auction) is being carried out by the Moscow property fund. The stock company "Stomatologia" definitely presents an interest for those that want to establish control over the commercial perspectives of this branch of medicine. However, one needs to know that under the stock company's privatization variant, 51 % of the shares already belong to a very narrow working collective. . .

#12, IPCC, vol 12, (Delovoy Mir N41, 1994, 02.25)

THE PRIVATIZED KAZAN PLANT OF MEDICAL EQUIPMENT (CHARTER FUND-OVER 3.5 BILLION RUBLES) DECIDED TO SELL UP TO 20 PERCENT OF STOCK TO FOREIGN INVESTORS

Prepared to become shareholders are firms from the U.S., Germany, Israel, with which there is already tentative partnership agreements. The plant manufactures unique medical instruments which have sales potential for foreign markets. The enterprise is interested in attracting foreign investors for the development of its industry and implementation of new technologies. Already, on the plant around 60 percent of the equipment is imported. Participation of foreign investors in organizational structure of the plant, will in the opinion of the plant's management, continue to improve the technical base, keeping equipment in working order.

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#137, IPCC, vol 11, (Delovoy Mir, N217, 1993, 11.07)

MIKHAIL SPOVSKY, HEAD OF THE RF HEALTH MINISTRY DEPARTMENT OF MEDICAL SUPPLIES, SPEAKS ABOUT HIS ATTITUDE TOWARD THE ACTIVITY OF SMALL AND MEDIUM-SIZE BUSINESSES INVOLVED IN WHOLESALE DRUG TRADE

The leadership of the health ministry in general supports the activity of commercial forms, which fulfil today those niches of the market that cannot be effectively served by the state sector.

Mikhail Spovsky said that in Moscow alone some 250 private, mixed firms, joint ventures and associations have gotten licenses on the right to sell pharmaceutical goods and act as pharmacies. Such newly formed commercial forms have become active competitors of state structures, they often offer more profitable conditions for the supplying of medicines, and closely follow supply and demand. They work without subsidies and special benefits for small and medium businesses. using commercial credits for the quick creation of revolving funds.

8.3 Fearful of Privatization and Change of Ownership Structure

#2, IPCC vol 12, (PF, 1993, 01.06)

CHAIRMAN OF KRASNOPRESNENSKY DISTRICT COUNCIL ALEXANDER KRASNOV CIRCULATED AN OPEN LETTER TO MOSCOW MAYOR YURI LUZHKOV

The cause for the writing of this concerned the declaration by the Moscow government. . . on the creation of hospices in Moscow. . .there are plans to build a 25 bed hospice on the site of a hospital, which serves some 15 thousand . . .

In the opinion of Aleksander Krasnova, the creation of a hospice on the site of a recently reconstructed hospital with hospital equipment and staff being left on the street is untenable. . .

#5, IPCC vol 12, (PF, 1993, 06.23)

AUCTIONING OF MEDICAL GOODS MANUFACTURER INCOMPATIBLE IN TULA REGION

Such a resolution was passed by the Tula Oblast Medical Committee, looking at the state of affairs at the firm "Medtechnika," whose management would like to auction the company.

On a meeting held at the company many opponents voiced there opinion. Representatives of medical institutions in Tula complained that "Medtechnika" would exploit its monopolistic position [even more if sold off and the company would stop providing medical institutions with individually made

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pieces of equipment.

8.4 Privatization But Not Overly Fast and Only as Needed

#221, IPCC vol 11, (Rossiiskiye Vesti N42, 1994, 3.10)

OFTEN CRUCIAL DECISIONS ARE BASED ON DOUBTFUL INFORMATION

All newspapers are filled with descriptions of the wonders of paid [and privatized] medicine. . .[in the West]. "We have to rush to have a system like their's." . . . However, it seems that in many so-called civilized countries, the state continues to support care. .. And they say we need radical reforms. For example, it's known to everyone that in the U.S. the state supports fundamental science and higher education, . . . and agriculture-[without this support] these institutions would long ago have disappeared. In other words, society transfers its values into great fields on the principles of practical value, of social justice.

And as if it is not strange, our society has kept quiet about or even ignored the fact that throughout the whole world enterprises [medical and otherwise] are becoming the property of their workers. . . Under such a form of ownership one gets the most rapid increase in labor productivity, and with increasing the quality of goods [and services] produced.

8.5 Conclusion

Ironically, not really any of the sources had the average consumer's or average provider's opinion on what privatization means to him or her. Most likely it is because such people are too busy trying to survive to be thinking about anything else.

Privatization is not doomed in Russia. Between the businessman and the bureaucrats a golden mean is reachable: privatize you may, but make sure that such a change will really bring about solid benefits and that the process removes rather than adds to social tension. Spacing the process over time helps. Finally, specific national priorities for support by the state need to be determined and followed through.

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HEALTHY RUSSIA 2000-FOCUS GROUP FINDINGS

I. Background and Purpose:

A. Ten health care provider and consumer focus groups were conducted in June, 1994 in the Russian cities of Khabarovsk, Novosibirsk, Krasnodar and Vladimir, respectively representing Russia's Far Eastern, Siberian, South and Central regions. The groups were held for IBTCI under the direction of Mr. Vladimir G. Andrenko, of the Moscow based Institute for Comparative Social Research. Further processing of the 20 hours of tape was completed by The Tarrance Group, of Alexandria, Virginia and IBTCI's Moscow office.

B. The purpose of the focus groups was to gain a sense of the feelings, opinions, and perceptions held by consumers and providers on various issues related to the present state of the Russian health care system.

II. Methodology:

A. Each group was approximately 2 hours in length, with an average of 10 people per group. An attempt was made to vary the types of provider and consumer groups interviewed. Provider groups varied in terms of status ranging from upper level administrative health officials to mid-level medical personal. Consumer groups varied as well in terms of age and sex.

B. The discussion framework for each of the groups centered around general questions relating to the state of Russian health care. The attempt was made to gather comments which encompassed the system as a whole rather than only the local parts.

III. Prime Subject Matter:

A.) System Overview
B.) Situation of Russian Medical Personal
C.) Financing of Care
D.) Changes in Ownership and Administrative Structures of the Russian Health Care System
E.) Health Awareness of the Russian People

A. System Overview:

1. Overall Opinion

The overall opinion among the consumers and providers of the groups was of a once stable health care system which is now veering towards disaster. Commonly heard expressions from both consumers and providers consisted of "We are deep in the sticks," or "We need to get a perspective

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from the Center," indicating that not only is the system in trouble but no one seems to know the way out; "How is it possible to develop anything when in today's chaos we cannot even identify the general parameters?" one provider asked.

Most providers voiced a nostalgia for the state system that they had been rooted in and a sense of bewilderment at today's rapidly changing situation:

"Some 20 to 30 years ago we were nearer to the West's level. But now in the West, there has been a tremendous leap forward, while we have started lagging behind. . . . In the old days the health care system had a particular bit of functions which were precisely defined, now we have no one taking any responsibility. Everybody talks about it -- no one does anything. . . . Something has to be changed, but of the options which are available to us, we don't really see a real way out. . . . We now have alleged freedom but in fact we have been left to our own devices -- the state does not guarantee social security. The state is simply washing its hands of our problems. . . Patients are demanding what used to be possible what used to be due, doctors cannot do anything -- this is where the psychological barrier becomes insurmountable."

The one exception in the midst of all this pessimism is the belief that despite the country's general crisis "the health care system is surviving due to attitudes of responsibility of our personnel" and that at least now there is more freedom for individual doctors to innovate and create than there was earlier.

Consumer sentiments basically echo those of the providers, however, they have less respect for Russian medical personnel (see situation of Russian medical personnel). They tend to want the state to bring order to the system and help them with the "grievous problem of survival."

2.) Problems related to Pharmaceuticals and Equipment

In the words of one consumer, even the most elementary pharmaceutical products have risen in expense to the point where a person in need of medication "must come ashore on his own." This sentiment is also echoed by providers who complain of major ruptures in inputs from former Soviet republics, while they think that new suppliers see everything as "just a spot deal," and cannot be trusted. Although there is the desire to use more western medicines a lack of money and proper supply channels prevent this from taking place.

Many consumers mentioned that a doctor will write them a prescription," saying this is the medication you need but I don't know where you are going to find it." One provider mentioned "that if we want to provide medications to our patients for free then our drug stores start depending on the fact of whether or not the city financial department will compensate them for this." In short, both consumers and providers are physically and psychologically stretched to the limit due to inefficient distribution and the rising prices of pharmaceuticals.

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In terms of the supply of medical equipment, providers mentioned that anything leftover from other industries is then allocated to medicine. On the whole, providers mentioned that much of their heavy equipment is old and breaking down, with replacements being in short supply or too expensive. Moreover, basic things such as soap, scalpels, etc., are not always in adequate enough quantities. But providers did not seem enthused about the old equipment supply system:

"At least now if you've got the money you can buy whatever you need, whereas under the old system the only thing you could buy was junk. . . . Sometimes in the old system we could not get anything, other times we had stuff thrown upon us, or equipment delivered 5 years too late by which time we would have already purchased it."

Provider comments on pharmaceuticals and equipment give the impression of a present system unable to function properly due to the lack of basic supplies.

3.) Problems with Infrastructure/Medical Services

Major problems are occurring in this area as well. If most provider comments are any indication, maintaince and capital overhauls of the health care infrastructure have practically stopped occurring. Or as one provider mentioned: "The only time anything really is renovated is if a beam is practically falling down. Then the hospital will prop it up again. But how it props is up again is its own headache." The sense is that nothing is being done to prevent major infrastructural collapse. Also expressed among many groups, was the idea that out in the provinces the health care system is totally disrupted, and that people from outlying areas cannot even make it to the city for treatment because they don't have the funds and providers are not going to see them because they don't have the transport funds either.

Ironically, while providers praise the old system in one breath, in the next they criticize its legacy to present medical services. As one provider mentioned, "the Soviet/Russian health care system has always been possessed by excessive quantity, i.e., more people in white overalls and each one receiving less salary: the whole system is based on the principle of numbers." In terms of quality one insightful respondent mentioned that "in a day when mass injections and pill-popping have come to represent a lack of service rather than a plus, our country administers more such injections and pops more pills than anyone else." The conlusion is that massive, inflexible quantity-based programs are taking precedence and funding from more individualized quality- based medical service programs.

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B. Situation of Russian Medical Personal

1.) Administrative and Societal Indifference towards Russian Medical Personal

From provider comments, one reaches the conclusion that society at large takes the labor of Russian medical personnel for granted and does not give them the status that their colleagues are accorded in the West.

Mid-level personnel complain of upper level administrative indifference to their problems and concerns. In a word, they feel that authorities do not understand the health care situation and take no responsibility for any of their actions which influence it. The general belief voiced over and over again by provider comments is that the only thing holding up the "crashing Russian health care system is the sheer enthusiasm of Russian medical providers who are acting like shock absorbers." Providers mention that while a large number of decrees in favor of Russian medical personal have been passed, none of them have actually been carried out. Providers also say that the public does not respect them as professionals: "We are down to our heels and our nose is kept to the grindstone, but nothing has been done in terms of changing public attitude."

In light of the above, it comes as no surprise that many providers mention the growth of a psychological sentiment of indifference, elusiveness and apathy among some medical professionals. Moreover there is frustration over the general state of Russia's economy and its medical infrastructure: "How can we introduce new services when our population is not in a state to fully pay for the services that they are presently getting." The conclusion reached is that while providers are the backbone of the Russian health care system, the administrators and consumers of the system do not give them adequate physical and moral support:

"While in America, doctors are esteemed professionals, here they are petty service technicians. Often my daughter [who is a doctor] comes home saying that if anyone asked her who her last 5 patients were she would not be able to tell. At 150 thousand rubles a month she is expected to see 30 patients a day. How can I expect my daughter to do her work when her main concern is thinking about how to keep her family fed. The only way out for medical personnel is a lesser work load and a higher salary."

Perhaps the issue that draws the greatest complaint from Russian medical providers is the lack of adequate compensation for their labors. In the words of one group participant, Russian "medical people are unaware of how much their labor really costs," i.e., in terms of the work they do, Russian health care professionals are paid incredibly meager salaries especially compared to their western counterparts. Everyone echoed the thought that rates based on provider qualifications, quality of care, and number of patients seen were inadequate: "If I treat more people, 150 as opposed to 100, the profit from this should go to strengthening my division and generating a profit for my staff, but under the system as it is now we end up getting a very small percentage of the total costs" of care.

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Listening to the provider tapes one detects the implied rising of an ultimatum: If we, the medical professionals of Russia, are to be providing quality care, we need to be paid adequately for our labors. However, it should be noted, that concrete solutions among providers on implementing a new reimbursement system are for the most part lacking, except for the generally shared opinion that the leveling of salaries is bad, and that there needs to be an established procedure for the measuring and paying of labor.

2.) Consumer Lack of Trust towards Medical Professionals

The flipside of the coin is the general consumer belief that doctors are not fully competent and that they cannot be trusted to provide reliable, quality care. The sentiments expressed are bleak:

"No matter where I applied they would just give me some shots and nothing else, saying 'off with you. . . .' While being treated at the hospital it appeared that doctors did not know what was wrong with me-they would look at me, pass me around, and give me some injections. . . . I was told I had stomach cancer only to realize that my results had gotten mixed up with someone else's. . . . Doctors do not know how to give an injection, conduct a diagnosis, prescribe a medication. . . . In the hospital they are helping you somehow, but if you apply there with something serious you can die there and they won't help you--Doctors try to shun the most essential responsibilities. . . . Doctors were very rude and forceful in trying to get me to have an operation that I did not need. . . . What good is there in complaining, you will be left unattended if you complain too much."

In addition, there are nagging irritations at rigid appointment schedules and hours spent waiting in line. Coupled with this is the belief that what was once a system centered around ethical responsibility towards the patient has become one centered around money, with responsibility in short supply.

Some consumers suggest going back to traditional healers, others have taken to treating themselves. Everyone expressed the need for providers who will take personal responsibility for what they are doing. Happily, some consumers mentioned doctors who would not accept under the table payments and actually were concerned about their patients. However, just as providers feel that consumers are a bit indifferent to their individual concerns, most consumers feel the same way about the majority of medical professionals serving them.

C. Financing of Care

1.) Medical Insurance

Both consumers and providers realize the financial mechanism of the Russian health care system needs to change. "The financing of care is at the head of the angle," says one provider. As for the new health insurance system, while group participants acknowledge its possible theoretical

importance they fault the system's practical implementation. "We were recently convinced of the importance of the new insurance program--our present financial mechanism is eating up all our financial resources--resources which could be better spent," says one provider. However, evaluations of how the present health insurance system is working are less than positive. Disillusionment has set in. In the words of various providers:

"The medical insurance system gives off a show of doing alot, but in fact it is just consuming money. . . . There are hardly any ripples of reform in the actual system itself. . . . The system is just one new 'transformation from the top,'--a very common thing to which no expectations should be held. . . . The law had tremendous potential but its implementation has proved to be such a sluggish process. . . . At the beginning there was the idea that insurance allocations would come in addition to state allocations, but now we are realizing that they are simply replacing state funding, for the most part the level of funding of the latter is the same as the former."

Feelings of providers verge to levels of distrust to those running the system especially in terms of the financial distribution of insurance funds:

"Financial organs and the Government are keeping the population in the dark in terms of their rights under the new health insurance system, they are using the whole situation as an opportunity to enrich themselves. . . . Money has not been collected properly or circulated properly. . . . Unfortunately, under the new insurance system while responsibility for care has been placed solely on doctors all financial leverage stays with financiers- not with bodies involved in organizing the system or which are aware of its needs. . . . Maybe the insurance system is a good idea, but I don't want an outsider controlling my payrolls. . . . The territorial funds and the insurance companies are really taking the leverage and control out of our hands."

Such sentiments also apply to consumers, as one participant says: "I would like to keep track of money flow, of what goes to whom, so that the patient could be sure that he is the center of this little universe."

Finally there is skepticism about the financial base of the entire health insurance system. Providers and consumers do not feel that the 3.6% tax is adequate enough, nor that most enterprises will be in a position to pay it. With industrial enterprises suffering from economic dislocation across Russia, participants question, "How can we start this new medical insurance system if the whole source of funding is not present?" And still other providers ask, "Where will the money come for hospitals not formally part of the new insurance program, for people who are refugees or not formally employed?" Moreover, almost all providers expressed sentiments that the payments received by hospitals from insurance companies are not adequately indexed for inflation and that the paperwork involved with such payments is exceedingly tedious and tiresome to complete.

Thus, while many participants acknowledged the need for some kind of insurance financed health

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care system, it appears that they view such a system as more of a future ideal than a present reality.

2.) Paid Services

Most participants voiced a very conservative view regarding paid services. The general belief among consumers and providers in the groups is that only a small percentage of people can afford paid services. One provider asked the question, "How can we choose from the non-existent finances of our people what to make paid for?" As if speaking for all, another echoed, "For as long as our society is not stable, for as long as our society is not rich, nothing should be excluded from the free health care system, nothing. . . . Paid services can only exist when the standard of living of the population is high." Mentioned in various sentiments was the idea that the psychology of Russian doctors is such that they are not used to charging for services, while the psychology of the people is such that they are not used to paying for them:

"Of course it is more profitable to be earning more but we should think about the nation. . . . Where is the justice if a Soviet citizen has spent his whole life having his salary deducted to finance care and then suddenly he is told that he has to pay, we are very worried and very apprehensive that we must pay for operations and for things like syringes. . . . Nothing positive has happened--commercialization of the medical industry has brought back no good results- this is not the industry where you can be making money."

However, although in the minority, alternative view-points exist. Many consumers see paid services as a sheer necessity:

"Despite our financial hardships we would pay for an operation in order not to run the risk of being ill-treated. . . . People need to be prepared to pay, for the most part people still have the belief that everything should be provided for at a price close to nothing-people have no idea of the high cost of medical services."

Some providers have this point of view as well:

"We got slapped in the face when we were told that we cannot charge anything for preventive examinations. If we have no money to pay our salaries and to buy reagents for our laboratories why should we service the workers of major enterprises for free? Why should we service those well off? There should be a solid legislative and normative base for the administration of paid services."

But for the most part, when asked what types of care should remain free or inexpensive, providers and consumers mentioned things like: emergency, research work, maternal care, pediatric care, preventive care, pensioners, pharmaceuticals, major operations, sexually transmitted diseases, social diseases such as TB, vaccinations, psychiatric care, and oncological operations. For paid services the list is more concise: Added hospital comforts, dental work, contraceptives, eyeglasses, and

possibly abortion.

Over and over again the sentiment was voiced that any problems with the financing of medical organizations should not be solved by paid services but by greater allocations from the municipal and federal budgets: Rather than trying to solve their financial problems on their own with paid services or some other self-thought out solution, many providers continue to look to the state as the ultimate means of support. Since the old state financed system has been breaking down, many providers cynically view their prospects: "Our main problem becomes one of survival, i.e., how we can pinch another penny from our poor and suffering population." Thus it appears that providers are not so much against paid services as they are without adequate enough direction on how to prosper financially.

D.) Changes in Ownership and Administrative Structures

1.) Productive Change vs. Charlatanism

What was repeatedly mentioned by both consumers and providers was that ultimately it is not the type of ownership structure of a health care facility that is important, but the quality of individuals managing the enterprise. Alternative administrative/privatized structures to the defunct state run system are acceptable, assuming such structures consist of skilled individuals with authoritative stature. What is definitely not an option is a new form of management just for its own sake with "with those that manage getting the good money and everyone else being just as badly off as before." For example, one provider refers to a hospital trust as having the "same old bureaucrats and bribery--maybe in 50 years we will be ready for such a system."

A general sentiment of consumers and providers is that a private institution would gradually, although not quickly, gain the confidence of the people if they felt that such an institution was truly feeling personally responsible and motivated in providing a quality level of care. Opinions on the quality of privatized care vary:

" I trust a private doctor, he is a self-made person surviving on his own--he is a concrete individual who I know and can be held responsible. . . . When a private doctor charges a certain amount of money for his patients, the level of responsibility he takes for each patient increases dramatically."

"If private practioners are working with good quality let them, but more often than not it is not that much of an impressive performance. . . . In many cases its a nice sign above the entrance, but inside they are just swindlers and nothing else. . . . Many times patients are lured by so-called 'private healers,' they end up coming to us in an awful state."

Everyone shares the same ideal: A new administrative structure in the health care system that emphasizes quality and responsibility. However, while some view new administrative structures and

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personal as reviving the system, others see the word "new" as representing nothing more than changes at the cosmetic level in order to fool the public into believing that real strides in quality have occurred.

2.) Obstacles to Change

While consumers and providers might be for a certain changes in administration and ownership, they feel that major, perhaps insurmountable, roadblocks exist, especially of a financial nature. As with paid services, participants ask "How can privatized, for-pay institutions be established when people cannot pay for them?" One provider says that creating a hospital trust is impossible, " because we don't have any groups of rich, conscientious citizens." Privatization has been said to become so complex a process that "not even Fydorov could break through today's situation. . . . The taxes are high--up to 60%" There exists the belief that there is "no way to organize good surgical and diagnostic services into small-semi private companies because of the expense involved."

Finally, just as significant as the financial obstacles, are the psychological obstacles to change. "I am fearful," remarks one consumer, "no one has tested the privatized system yet and I don't want to be a guinea pig." A provider mentions that "cooperization could mean large numbers of medical personal getting sacked. We have spent so many years working within state organizations--it is the only world we know." A health care administrator says that "problems in our sphere need to be handled by the state until there is a unified state policy in all aspects there will be chaos. . . Drug stores were privatized and now there is complete chaos- God forbid us to ever see it again, it would be terrible."

The general consensus of both consumers and providers was a desire for the process of privatization to be drawn out over some length of time, with the people heading the process needing to be "extremely competent" individuals. Cautious to the point of pessimism, nevertheless, participants voice tentative support of privatization and other changes in ownership structure provided that the process has "a clear cut program and good supporting legislation." In essence, if consumers and providers are expected to make adjustments in order to support system reform, they must see significant and lasting payoffs sooner rather than later if their support is to be gathered.

E.) Health Awareness of the Russian People

1.) External Factors Limiting Health Awareness

Most participants mentioned "that people are extremely wound up about economic problems to the point where they cannot give their health any heed"- "Only a well off person would come in to ask questions regarding his health," remarked one provider. "If anything," said one medical provider, "people needing extended care are afraid to seek it for fear of losing their jobs. Patients are telling us: Please release us or I'll be given the sack for being sick so long."

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Also mentioned was that besides economic uncertainties, many citizens of Russia suffer from alienation, from the feeling that they do not matter to their country. As one participant mentioned "if a person feels needed by the state and by the community he will automatically want to support a healthy lifestyle, where as with us this 2 by 2 concept is lacking. . . People just don't know if they are needed or not." Furthering this alienation, are "overwhelming ecological problems, which cannot be helped," and the "emigration of valuable medical specialists."

Participants feel that in order to bring people to pay more attention to their health their "economic sense of instability and worry" must be lessened. Finally, they feel that the government needs to "ask itself the question of what it needs a healthy population for," hopefully coming to the conclusion that a healthy population is an issue of central importance. The overall sense is that participants want "stability and organization" in their lives and feel that the state has been taking them and their usefulness to the country for granted too long. Again and again, one hears the question of "How can people pay for care if they are at the social bottom of life?" There is the echoing sentiment that in Russia "the survival level of the people must be held up," which will mean among other things repairing "the major problems with infrastructure."

2.) The Need for New Attitudes and Lifestyle Changes

While on one hand participants argue for the government to take action regarding people's health, on the other they say "that much in terms of health depends on the patient." Providers above all voice the sentiment that unfortunately "all responsibility for a patient's health is put on the doctor. Why can't a person himself take personal responsibility for his health. Everything surrounding us in the external environment is of importance--maybe only 10% depends on a doctor."

Providers mention that while preventive measures are well organized in the West, "we live where we should not live, eat what we should not eat, drink what we should not drink." There are many references to "excessive smoking and alcoholism," to the belief that the "population does not hold health as a great value in their lives." Better preventive care at the state and individual levels must be instituted: "People are coming to our hospital in a very grievous state when in reality lots of things could have been done earlier. Patients are badly informed on how to take care of their health." Another participant said that "People are trusting their health to all kinds of quacks, they are seeing newspaper advertisements of the type 'I am treating all types of sugar diabetes.'" Finally, government efforts on increasing consumer health awareness must be revived "as it is difficult to say how people are responding to present public education/preventive measures."

The ultimate conclusion is that both the state and individuals themselves must take more responsibility in providing for a healthy lifestyle. But above all, the political and economic conditions of the country must improve because many of the health problems of the Russian people are directly related to the excessive tension and instability now present in their lives.

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ANNEX III
REFERENCE CHARTS

Table 1
Health of population

Life Expectancy	1990	1991	1992	1993
Male	63.8	63.5	62	60.0
Female	74.3	74.3	73.8	72.5
Death Rate (per 1000 population)		11.4	12.2	14.5
Infant Death Rate (10000 births)		178.2	180.5	199
Birth Rate (per 1000 population)	13.4	12.1	10.8	9.4
Abortion Rate (per 100 births including stillborn)	200.8	205.6	207	

Source: PJP Publications Ltd, SCRIP Reports, August 1993, p.198, Goskomstat, Statistics Department

Table 2
Institutional resources

	1990	1991	1992	1993	OECD 1990
Hospitals (thousands)	12.8	12.7	12.6	12.5	
Beds (thousands)	2,037.6	1,998.7	1,898.8	1,890	
Beds (per 10,000 population)	137.5	134.7	127.7	126.8	90.1
Polyclinics (thousands)	21.5	20.8	20.0		
Visits per shift (thousands)	3,222	3,272	3,321	3,322	
Visits shift (per 10,000 population)	217	221	224	224	

Source: Goskomstat, 1992 Medical service of population in RF, Statistics Department[1]

[1]"Visits per shift" is a measure of polyclinic capacity which shows a maximum number of patients a polyclinic can serve per eight hour shift assuming 100% staffing. This measure is used in the Russian health-care

Table 3
Conditions of Hospitals and Polyclinics in Use in 1988

Conditions	Hospitals	Polyclinics
Disastrous	9%	5%
Requires reconstruction	14%	14%
Requires repair	32%	30%
Requires slight repair	30%	34%
Good conditions	15%	17%
Total	100%	100%

Source: World Bank Report, *Health Sector Reform in Russia: The Health Finance Perspective,* Dec 1993 based on Goskomstat, 1989 Yearbook of Health Statistics

Table 4
Conditions of Hospital and Polyclinics Buildings in Use in 1988

Buildings without:		
Sewer connection	24%	15%
Central Heating	19%	12%
Bath/Shower	45%	52%
Electricity	1%	1%

Source: World Bank Report, *Health Sector Reform in Russia: The Health Finance Perspective,* Dec 1993 based on Goskomstat, 1989 Yearbook of Health Statistics

Table 5
Construction of New Capacity

	1985	1991	1992	92/91
New Hospital Capacity (beds)	31,441	17,426	8,151	47%
New Polyclinic Capacity (visits/shift)	76,340	62,508	39,636	63%

Source: Goskomstat, *Medical Service in Russian Federation in 1992*

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statistic (something missing; hope it's on the BCG disk - JB)

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Table 6
Human Resources

	1990	1991	1992	1993
Number of doctors (thousands)	694.7	657.6	662.8	663
Number of doctors (per 10,000 population)	46.9	44.3	44.7	45
Number of paramedicals (thousands)	1,816.7	1,691.1	1,684	1,680
Number of paramedicals (per 10,000 population)	122.5	114.1	113.6	113
Number of medical students (thousands)		214	217	

Source: Goskomstat, 1992 Medical service of population in RF.

Table 7
Wages in Health Care (Rb per month)

Year	1991	1992	1993	1994/qtr
Average Salary in Health Care (current Rb)	580	5,654	44,232	122,643
Retail Price Index	1.0	26.0	10.0	3.6
Average Salary in Health Care (1991 Rb)	580	217	170	131
CAGR		-167%	-28%	-30%

Source: Goskomstat RF, Department of statistical publications

Table 8
Russia: Local Production 1992

Type	Number of enterprises	BR in 1992
Synthetics	11	16.4
Finished drugs	12	14.0
Vitamins	7	10.9
Antibiotics	17	16.3
Vaccines	7	1.5
Plant derived	2	0.8
Plastics	12	6.3
Medical equipment	23	8.2
Total	91	74.4

Table 9
Russia: Fulfillment of demand 1992-1993

%	1992		1993	
	Domestic production	+ Imports	Domestic production	+Imports
Cardiovascular	59	91	35	65
Psychotropics	43	74	33	68
Antitumour	45	75	22	70
Antibiotics	59	80	54	78
Analgesics	29	90	31	88
Antiseptics	85	94	41	47
Sulphonamides	65	84	50	23
Blood substitutes	40	79	75	88

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Table 10
Pharmaceutical Wholesalers

Country	Warehouses		Pharmacies/ Warehouses
	Warehouses No.	Average sales ($ million)	
Germany	105	152	172
France	227	66	97
Italy	353	28	45
UK	65	115	183
Spain	189	32	95
Average EC	na	58	92
Hungary	32	16	63
Russia (est.)	133	3-25	120

Table 11

Country	National full-line wholesalers				Regional full-line wholesalers			
	No. Companies	No. of Warehouses	W/h per company	% of total market	No.	No. of Warehouses	W/h per company	% of total market
Germany	5	70	12.0	80	17	35	2.0	20
France	17	218	12.8	97	2	7	3.5	3
UK	2	39	19.5	70	24	27	1.2	30
Italy	8	120	15.0	50	100	160	1.6	50
Spain	3	60	20.0	30	82	140	1.7	70
Sweden	2	7	3.5	100	0	0	0.0	0
Switzerland	2	8	4.0	70	4	4	1.0	30
Hungary	1	3	3.0	22	23	29	1.3	78
Russia*	3	5	1.7	<10%	100**	130	1.3	<90%

* Estimated

** The number would be increased by 50-100 wholesalers if small dealers operating without storage facilities are included.

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Table 12

Country	Pharmacies		Inhabitants/ pharmacy	No of items	
	No (000)	Avg. sales (K$)		Drugs (000)	Total (000)
Germany	18.1	884	3400	45.0	130.0
France	22.1	678	2600	7.0	20.0
Italy	16.0	625	3500	7.5	13.7
UK	11.9	630	5000	7.0	11.0
Spain	18.0	333	2200	9.5	18.0
Average EC	na	632	3300	17.0	38.0
Hungary	1.9	333	5400	2.7	6.0
Poland	5.2	115	7300	12.0	na
Russia	16	50-700	9400	2-3	na

Table 13
Trend in Government Health Care Expenditure, 1985 to 1993

Expenditure	1987	1988	1989	1990	1991	1992	1993
Nominal Total (Min.. Rbl)	10,817	11,892	13,732	16,018	36,693	314,200	3,600,000
Real Total (Min. Rbl)	26,269	28,565	31,414	34,279	36,693	19,114	23,182
Growth in Real Total (%)	6	9	10	9	7	-92	21
Real per Capita (Rbl)	180	194	212	230	248	129	156
Growth Rate per capita (%)	5	8	9	8	6	-92	21

Source: World Bank Report, *Health Sector Reform in Russia: The Health Finance Perspective*, Dec. 1993. Based on reanalysis of data from the MedSocEconomInformInstitute, Moscow. For years 1987-1991 the deflator was constructed from information in World Bank, Russian Economic Reform, 1992 and IMF and World bank, The Economy of the USSR, 1990. The deflator is 0.408, 0.412, 0.437, 0.467, 1.0 for 1985 to 1991. Deflators for 1992 and 1993 (17.85 and 8.7) are constructed as weighted averages of indexes of wages in health care and retail prices based on Goskomstat data and Starodubov V.I. "Health at the Working Place, 31.05.94.

Table 14
Recurrent Government Health Expenditures by Function (%)

Recipient	1989	1990	1991
Hospitals	71.4	69.3	66.6
Ambulatory Clinics	9.1	8.9	9.5
Other Centers	5.3	8.1	11.8
Emergency	2.0	2.0	2.3
Blood Centers	1.0	0.9	0.8
All Facilities	88.8	89.3	91.0
Public Health	3.1	3.1	3.2
Education and Research	5.7	4.9	2.2
Other	2.4	2.7	3.6
Total	100.0	100.0	100.0

a. including 2.6 and 2.4 percent for Sanitoriums in 1989 and 1990, respectively. Also includes residual TMA after deducting TMA payments to hospitals and emergency centers. Most of this residual is ambulatory. The TMU residual was 5.6 and 9.3 percent in 1990 and 1991, respectively.
Source: World Bank Report, *Health Sector Reform in Russia: The Health Finance Perspective,* Dec. 1993

Table 15
Health Budget Expenditure in the Russian Federation, 1992

	1992 Actual Budget					
	Consolidated Budget		of which:			
Budget Indicator	(bin Rb)	%	Federal	%	Regional	%
Health Expenditure	341.2	100	67.4	100	273.8	100
of which:						
Wages	128.5	38	30.6	46	97.9	36
Social Insurance Contribution	48.8	14	11.6	17	37.2	13
Material Expenses	163.9	48	25.2	37	138.7	51
Health Budget Expenditure Per Capita (000 Rb)	2.3					
Health Share of State Budget (%)	6.2		1.7		16.8	
Health Share of GDP (%)	2.3					

Source: PIP Publications, SCRIP reports, December 1993, based on Byudzhemoe Poslanie na 1992 God (1992), Byudzhemoe Poslanie na 1993 God (1993), pg. 397, and estimates.

Table 16
Levels and Distribution of Health Finance, 1989 - 1992

	1989	1990	1991
a. MOH system Local Federal	78.42 % 75.52 % 2.91 %	78.99 % 76.01 % 2.98 %	82.44 % 79.35 % 3.09 %
b. Parallel Systems	7.51 %	8.12 %	8.70 %
c. Private	14.07 %	12.89 %	8.87 %
Grand Total, min rbls, % of GDP	36.556 2.8	39,533 2.9	40,253 3.3

Source: World Bank Report, *Health Sector Reform in Russia*: The Health Finance Perspective, Dec. 1993.

Table 17
Distribution of private expenditure on health care, 1989 - 1992

	1989	1990	1991	1992
Fees	16.36 %	16.37 %	18.64 %	16.35 %
Pharmacy and Optics	83.64 %	83.63 %	81.36 %	83.65 %
Private, min. rubls.	5,141	5,095	3,670	3,009

Source: World Bank Report. Health Sector Reform in Russia: The Health Finance Perspective, Dec. 1993

Table 18

Table 18 summarizes some of the characteristics of each system in 1990, before the recent major changes in Russia. Note that in 1993, Russian officials estimated that black market expenditure on health care might well be 25% of total expenditure.

Country	Health Care Spend per capita ($/PPP's)	Health Care as % of GDP	Type of System	% of Public Financing
Russia 1990	121 [1]	2.9 [2]	tax financed	80 - 95 [3]
Russia 1993	31 [1]	>3.0 [3]	transition	<75 [3]
OECD Average	1204	7.6	-	74
Netherlands	1286	8.2	sick funds	71
Germany	1486	8.1	sick funds	73
UK	972	6.2	tax financed	84
Sweden	1451	8.6	tax financed	90
USA	2566	12.1	tax + insurance	42

Source: Health Care Financing Review 1992

Source (Russia): [1] BCG estimate [2] World Bank Dec. 1993 [3] Unpublished data from the Ministry of Health, Goskomstat

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Table 19

Source of Financing	1991	1992
Health Insurance Fund Act	32.9	23.9
Exceptional Medical Expenses Act	31.4	45.6
Government	10.6	10.7
Other Sources	25.0	19.9

Source: FOZ 1992

Table 20
Comparison of health care outcomes for Russia and 5 OECD countries (1990)

Country	Male Life Expectancy at Birth	Female Life Expectancy at Birth	Infant Mortality (Deaths/1,000)	Crude Birth Rate (per 1,000)
Russia 1990	63.9	74.3	17.4	13.4
Russia 1993	60.0	72.5	-	9.4
OECD Average	72.6	78.9	7.4	13.0
Netherlands	73.8	80.1	7.1	13.2
Germany	72.6	79.0	7.5	11.3
UK	72.8	78.5	7.9	13.9
Sweden	74.8	80.4	6.0	14.5
USA	72.0	78.8	9.1	16.7

Source: Health Care Financing Review 1992
Source (Russia): 1990 Unpublished Ministry of Health data; 1993 Goskomstat

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Table 21
Deviation between actual and need-based health expenditures in 1992.

TERRITORY	LOCAL HEALTH EXPENDITURES		
	ACTUAL MLN.RBS	NEED-BASED MLN.RBS	DEVIATION %
RUSSIA	413,789.0	302,862.5	36.63
NORTHERN REGION			
Karelia rep	2,941.4	1,896.5	55.09
Komi rep	5,300.6	2,806.3	88.88
Arkhangelskaya obl	4,887.4	3,613.2	35.27
Vologodskaya rep	3,932.5	3,321.7	18.39
Murmanskaya obl	5,810.5	2,288.0	153.95
NORTH-WESTERN REGION			
Saint-Petersburg	11,558.2	10,938.8	5.66
Leningradskaya obl	4,363.0	3,765.5	15.87
Novgorodskaya obl	1,885.6	1,759.5	7.17
Pskovskaya obl	1,963.8	1,988.6	-1.25
CENTRAL REGION			
Bryanskaya obl	2,801.7	3,037.2	-7.75
Vladimirskaya obl	3,788.8	3,498.9	8.28
Ivanovskaya obl	2,993.9	2,845.1	5.23
Kaluzhskaya obl	2,002.5	2,281.5	-12.23
Kostromskaya obl	1,883.9	1,725.8	9.16
Moscow	29,127.8	20,618.5	41.27
Moscow obl	13,759.8	14,193.4	-3.06
Orlovskaya obl	1,756.2	1,905.8	-7.85
Ryazanskaya obl	3,289.0	2,856.7	15.13
Smolenskaya obl	2,053.6	2,461.9	-16.58
Tverskaya obl	2,994.5	3,659.8	-18.18

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TERRITORY	LOCAL HEALTH EXPENDITURES		
	ACTUAL MLN.RBS	NEED-BASED MLN.RBS	DEVIATION %
Tulskaya obl	4,076.6	4,083.5	-0.17
Yaroslavskaya obl	3,580.2	3,061.1	16.96
VOLGO-VYATSKY REGION			
Mari-El rep	2,147.5	1,351.5	58.90
Mordovia rep	2,393.2	1,689.3	41.66
Chuvashia	3,150.3	2,349.3	34.09
Kirovskaya obl	4,096.4	3,100.6	32.12 %
Nizhegorodskaya obl	8,492.8	6,964.5	21.94
CENTRAL-CHERNOZEMNY REGION			
Belgorodskaya obl	3,186.3	2,474.4	28.77
Voronezhskaya obl	5,572.7	4,444.4	25.39
Kurskaya obl	2,707.7	2,478.6	9.24
Lipetskaya obl	3,386.8	2,191.4	54.55
Tambovskaya obl	2,786.1	2,414.1	15.41
POVOLZHSKY REGION			
Kalmykia-Khalm-Tang rep	868.2	515.8	68.32
Tataria rep	10,912.4	5,756.4	89.57
Astrakhanskaya obl	2,027.7	1,637.1	23.86
Volgogradskaya obl	5,792.8	4,330.1	33.78
Penzenskaya obl	2,820.2	2,455.2	14.87
Samarskaya obl	8,872.7	5,300.4	67.40
Saratovskaya obl	5,794.8	4,419.2	31.13
Ulyanovskaya obl	3,458.2	2,356.7	46.74
NORTHERN CAUCASES REGION			
Adygeya rep	876.0	912.1	-3.96
Dagestan rep	2,870.5	2,717.9	5.61

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TERRITORY	LOCAL HEALTH EXPENDITURES		
	ACTUAL MLN.RBS	NEED-BASED MLN.RBS	DEVIATION %
Kabardino-Balkaria rep	1,567.7	1,437.7	9.04
Karachaevo-Cherkessia rep	801.1	832.9	-3.82
Northern Osetia rep	1,411.4	1,206.1	17.02
Krasnodarsky krai	9,637.2	10,063.3	-4.23
Stavropolsky krai	3,939.0	5,109.9	-22.91
Rostovskaya obl	8,380.0	8,863.8	-5.46
URALS REGION			
Bashkiria rep	14,993.3	7,753.3	93.38
Udmurtia rep	3,787.1	3,207.7	18.06
Kurganskaya obl	2,642.1	2,243.2	17.79
Orenburgskaya obl	6,251.1	4,271.1	46.36
Permskaya obl	9,550.6	6,229.8	53.31
Sverdlovskaya obl	16,916.4	9,438.4	79.23
Chelyabinskaya obl	13,998.9	7,240.8	93.33
WESTERN SIBERIA REGION			
Gorny Altai rep	645.2	458.6	40.71
Altaysky krai	6,537.4	6,424.0	1.77
Kemerovskaya obl	12,292.7	6,768.8	81.61
Novosibirskaya obl	5,404.5	5,817.8	-7.10
Omskaya obl	6,642.9	4,402.7	50.88
Tomskaya obl	2,747.1	2,053.3	33.79
Tyumenskaya obl	18,690.1	5,657.9	230.34
EASTERN-SIBERIA REGION			
Buryatia rep	2,779.7	2,080.8	33.59
Tuva rep	1,257.8	674.1	86.59
Khakassia rep	1,536.3	1,186.9	29.44

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TERRITORY	LOCAL HEALTH EXPENDITURES		
	ACTUAL MLN.RBS	NEED-BASED MLN.RBS	DEVIATION %
Krasnoyarsky krai	12,269.3	6,060.2	102.46
Irkutskaya obl	9,009.0	5,766.0	56.24
Chitinskaya obl	3,718.7	2,691.9	38.15
FAR EAST REGION			
Yakutia-Sakha rep	9,174.6	2,828.6	224.35
Primorsky krai	6,485.6	6,488.0	-0.04
Khabarovsky krai	6,864.6	5,696.3	20.51
Amurskaya obl	2,865.4	2,898.7	-1.15
Kamchatskaya obl	2,498.3	1,169.6	113.60
Magadanskaya obl	3,623.6	1,040.0	248.41
Sakhalinskaya obl	3,829.0	1,969.3	94.43
KALININGRADSKAYA OBL	1,863.6	1,936.6	-3.77

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Table 22
Deviation between actual and need-based health funds under different allocation scenarios, mln. USD.

TERRITORY	First Scenario	Second Scenario	Third Scenario
RUSSIAN FEDERATION	513.6	932.9	141.7
NORTHERN REGION			
Karelia rep	3.5	4.4	-0.9
Komi rep	17.4	14.1	0.1
Arkhangelskaya obl	8.2	5.0	-5.1
Vologodskaya obl	4.7	12.0	4.4
Murmanskaya obl	14.6	19.3	7.7
NORTH-WESTERN REGION			
Snt-Petersburg	4.6	0.3	-22.0
Leningradskaya obl	2.7	9.5	2.3
Novgorodskaya obl	0.2	0.8	-2.6
Pskovskaya obl	-1.0	-0.5	-3.6
CENTRAL REGION			
Bryanskaya obl	0.2	1.8	-3.6
Vladimirskaya obl	2.4	10.3	2.7
Ivanovskaya obl	0.7	8.1	2.7
Kaluzhskaya obl	-0.4	-0.3	-4.3
Kostromskaya obl	1.0	1.8	-1.7
Moscow	18.3	14.3	-37.1
Moscow obl	8.6	8.8	-15.9
Orlovskaya obl	0.2	3.4	-0.2
Ryazanskaya obl	0.7	9.8	4.2
Smolenskaya obl	1.1	5.1	0.2
Tverskaya obl	1.4	2.4	-4.4
Tulskaya obl	4.3	9.7	0.5

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TERRITORY	First Scenario	Second Scenario	Third Scenario
Yaroslavskaya obl	3.7	16.0	8.7
VOLGO-VYATSKY REGION			
Mari-El rep	0.1	0.7	-1.8
Mordovia rep	1.0	3.5	0.0
Chuvashia rep	1.9	4.3	-0.7
Kirovskaya obl	5.2	7.8	0.1
Nizhegorodskaya obl	11.5	33.3	15.8
CENTRAL-CHERNOZEMNY REGION			
Belgorodskaya obl	7.8	15.2	7.9
Voronezhskaya obl	3.6	7.8	-1.0
Kurskaya obl	3.9	8.8	3.0
Lipetskaya obl	4.6	15.6	9.9
Tambovskaya obl	1.9	3.6	-1.3
POVOLZHSKY REGION			
Kalmykia-Khalm-Tang rep	0.0	0.2	-0.8
Tataria rep	15.8	37.6	20.4
Astrakhanskaya obl	2.0	1.0	-2.8
Volgogradskaya obl	10.9	21.7	9.8
Penzenskaya obl	1.4	4.5	-0.8
Samarskaya obl	22.2	52.9	33.7
Saratovskaya obl	6.2	13.9	3.1
Ulyanovskaya obl	5.6	10.9	4.4
NORTHERN CAUCASES REGION			
Adygeya rep	-0.1	-0.9	-2.1
Dagestan rep	-2.9	-6.0	-8.7
Kabardino-Balkaria rep	-1.0	-1.3	-3.2
Karachaevo-Cherkessia rep	-0.7	-0.3	-1.3

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TERRITORY	First Scenario	Second Scenario	Third Scenario
Northern Osetia rep	-0.7	-0.6	-2.2
Checheno-Ingushskaya rep	-2.9	-3.6	-5.5
Krasnodarsky krai	5.4	0.8	-16.6
Stavropolsky krai	0.5	0.5	-7.8
Rostovskaya obl	3.5	11.2	-7.3
URALS REGION			
Bashkiria rep	17.0	44.6	24.2
Udmurtia rep	3.2	8.4	0.5
Kurganskaya obl	1.4	2.5	-2.2
Orenburgskaya obl	11.0	18.5	6.7
Permskaya obl	14.2	28.8	11.1
Sverdlovskaya obl	32.5	58.6	27.8
Chelyabinskaya obl	22.0	40.0	18.8
WESTERN SIBERIA REGION			
Gorny Altai rep	-0.4	-0.9	-1.5
Altaysky krai	0.0	3.8	-8.0
Kemerovskaya obl	39.9	43.3	14.5
Novosibirskaya obl	3.8	3.1	-9.5
Omskaya obl	5.4	15.9	5.4
Tomskaya obl	5.7	7.2	0.8
Tyumenskaya obl	75.5	127.4	80.3
EASTERN-SIBERIA REGION			
Buryatia rep	4.7	1.1	-4.2
Tuva rep	-0.8	-1.7	-2.5
Khakassia rep	3.4	5.4	2.0
Krasnoyarsky krai	34.2	54.1	26.7
Irkutskaya obl	25.6	33.2	13.0

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TERRITORY	First Scenario	Second Scenario	Third Scenario
Chitinskaya obl	6.4	-0.3	-6.8
FAR EAST REGION			
Yakutia-Sakha rep	17.8	20.6	5.4
Primorsky krai	4.1	-1.1	-15.0
Khabarovsky krai	8.4	3.7	-9.1
Amurskaya obl	3.1	-0.4	-7.1
Kamchatskaya obl	3.7	1.5	-2.7
Magadanskaya obl	9.4	11.4	2.3
Sakhalinskaya obl	4.7	3.6	-2.7
KALININGRADSKAYA OBL	0.4	1.3	-2.3
FEDERAL SUBSIDIES	10.9	17.7	239.5
federal share of wage bill health tax (0.2%) as % to fed. subsidies	428%	263%	19%

Figure 1
Real Governmental Health Care Expenditures Declined by 95% in 1992
(million of 1991 Rb)

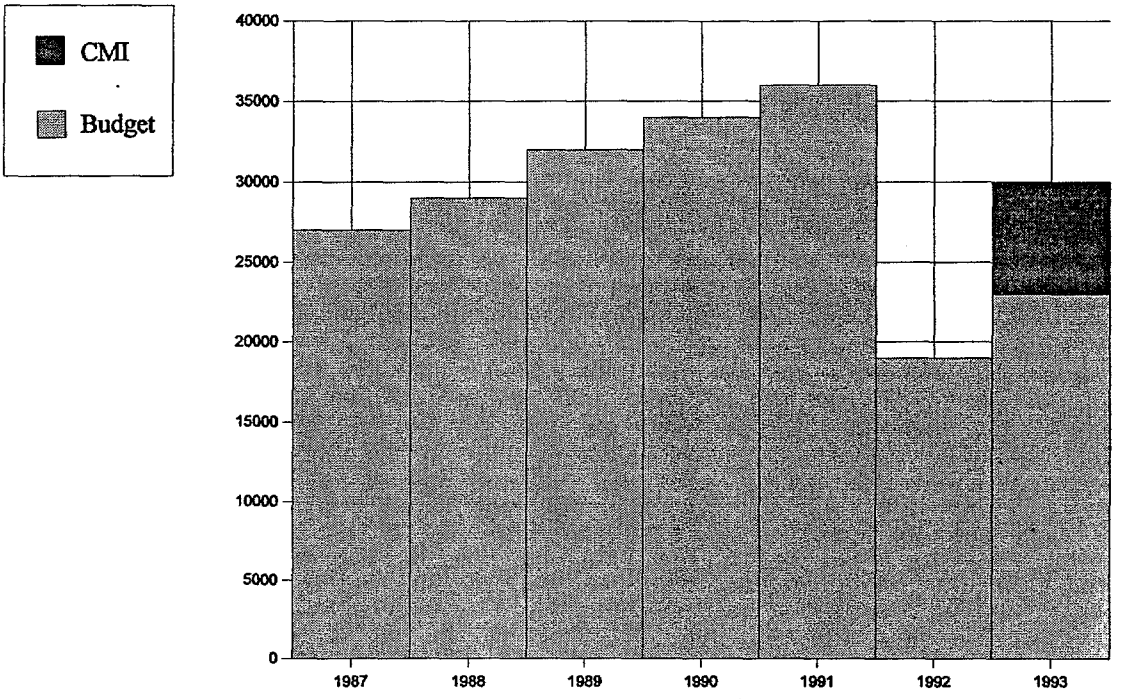

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Exhibit I
Death rate from diseases (per 100,000 population) in 1992

	Cardio Vascular	Cancer	Accidents & Poisoning	Infection of Respiratory Tract	Indigestion
RF	646.0	201.8	173.0	57.9	32.8
North Region	564.1	166.5	199.0	41.8	25.0
North West	790.3	267.0	200.8	46.0	38.5
Central	785.5	248.9	169.4	54.0	36.8
Volgo Vyatsky	685.7	189.5	175.2	81.8	28.0
Central Chernozemny	788.8	208.1	142.2	89.7	34.6
Povolzhie	643.5	206.8	143.5	46.7	31.1
North Caucasus	650.2	180.2	122.4	56.6	35.6
Urals	606.8	185.2	184.3	68.6	29.5
West Siberian	497.6	179.3	192.7	55.8	29.8
East Siberian	480.6	165.5	217.8	64.1	36.0
Far East	455.9	151.2	214.1	39.1	28.9

Source: Goskomstat, 1992 Medical Service of population in RF.

Exhibit II
Top 10 Disease in 1992 (per 1,000 population)

	Total Diseases	Infection Diseases	Diseases of nervous system	Cardio Vascular	Respira-tory System	Indiges-tion	Prostrate Diseases	Pregnancy Compli-cations	Skin Diseases	Ortho-paedics	Injuries and poison-ing
RF	615.6	34.9	50.6	11.5	289.7	31.2	22.3	34.9	35.7	25.6	82.9
North Region	679.7	45.6	46.0	9.1	305.5	20.4	21.0	33.8	37.0	28.3	85.9
North West	607.2	40.9	38.2	8.1	308.9	18.6	16.9	20.8	35.9	17.9	95.7
Central	621.0	33.0	47.5	11.2	317.8	22.8	25.0	29.0	32.9	24.9	80.3
Volgo Vyatsky	629.7	32.5	56.5	12.7	263.6	62.2	23.0	36.7	31.8	29.7	84.5
Central Chernoze-mny	532.7	29.5	48.3	12.5	239.5	22.3	20.5	29.1	34.3	27.4	69.0
Povolzhie	618.9	33.8	54.7	13.5	282.8	31.5	21.8	34.5	37.5	29.4	81.0
North Caucasus	514.1	27.5	47.7	13.0	220.7	29.4	23.2	27.3	35.6	21.0	69.0
Urals	646.3	36.5	54.8	11.2	296.5	36.9	21.8	50.8	35.7	21.0	69.0
West Siberian	681.5	40.9	57.4	12.6	305.3	37.6	29.5	41.5	41.4	29.0	93.0
East Siberian	587.8	34.3	48.4	9.5	275.3	36.2	21.8	34.1	30.5	21.6	80.0
Far East	673.0	39.7	51.2	9.2	331.2	31.9	25.2	40.1	44.0	24.2	83.0

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Exhibit III
Dynamics of diseases (per 100,000 population)

	Cancer			Influenza and Respiratory			Viral Hepatitis			Measles		
	1985	1991	1992	1985	1991	1992	1985	1991	1992	1985	1991	1992
RF	248	266	272	30,312	27,754	20,816	227	192	136	130.5	13.8	1
North Region	206	225	229	32,469	34,567	26,519	296	206	165	122.7	1.9	4
North West	301	315	324	38,712	35,466	23,798	171	160	160	46.3	7.6	1
Central	282	305	309	39,016	34,678	23,520	165	112	87	122.4	19.0	2
Volgo Vyat-sky	248	279	289	27,812	26,728	19,006	210	230	162	81.5	10.2	9
Central Chernoz emny	266	308	308	23,071	21,829	17,465	168	167	146	56.9	30.3	1
Povolz-hie	260	273	279	28,503	24,540	19,599	210	152	113	88.8	18.0	
North Cauc-asus	252	262	261	22,802	18,141	14,798	249	273	172	102.1	21.6	1
Urals	239	252	266	28,630	26,941	21,260	208	199	132	100.2	5.6	
West Siberian	222	237	266	29,200	26,996	21,405	211	241	139	285.3	5.1	1
East Siberian	183	206	207	23,923	23,928	19,278	397	268	181	271.6	8.7	
Far East	179	195	208	28,237	30,338	23,821	414	215	159	166.3	16.6	

Source: Goskomstat, 1992 Medical Service of Population in RF.

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Exhibit IV
Number of Sick Days claimed per employee per year

	1985	1991	1992	%92/91
RF	11.6	11.4	10.6	0.92
North Region	11.8	13.2	12.3	0.92
North West	12.4	13.1	11.2	0.85
Central	13.7	12.6	11.3	0.89
Volgo Vyatsky	10.9	12.1	10.2	0.84
Central.Chernozemny	11.3	12.4	10.9	0.87
Povolzhie	10.8	11.7	11.6	0.90
North Caucasus	0.9	0.9	0.8	0.833
Urals	11.6	0.9	10.4	1.10
West Siberian	11.0	10.5	10.9	1.04
East Siberian	11.6	12.3	11.2	0.91
Far East	11.8	12.8	10.9	0.84

Source: Goskomstat, 1992 Medical Service of Population in RF.

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Exhibit V
Doctors and Paramedical Staff (per 10,000 population)

	Doctors			Paramedical Staff		
Location:	1985	1991	1992	1985	1991	1992
RF	45.1	44.3	44.7	120.6	14.1	113.6
North Region	41.8	42.5	43.1	141.9	139.9	137.6
North West	66.0	54.6	55.2	134.3	108.9	109.1
Central	58.2	51.7	51.3	130.9	114.7	114.5
Volgo Vyatsky	35.5	38.1	39.7	111.5	109.8	108.7
Central Chernozemny	34.7	36.6	37.7	109.1	106.2	110.5
Povolzhie	40.9	43.0	43.8	116.5	115.1	113.1
North Caucasus	40.4	41.8	41.6	108.8	111.3	108.2
Urals	37.0	38.8	39.5	115.6	114.4	116.1
West Siberian	41.7	43.8	43.5	119.4	114.7	112.7
East Siberian	38.4	39.9	41.7	111.8	110.2	111.1
Far East	46.9	50.7	50.8	120.6	115.4	116.1

Source: Goskomstat, 1992 Medical Service of Population in RF.

Exhibit VI
Perm Region
1993 Budget for Health Care (millions of roubles)

	Region	%
Wages	25,001	26.0
Social Security	8,834	10.0
Pharmaceuticals	8,240	9.0
Equipment	8,926	10.0
Food	7,355	8.0
Utilities	11,265	12.0
R&M	6,856	7.0
Capital Investment	4,302	4.0

Exhibit VII
Tver Region
1993 Budget for Health Care (millions of roubles)

	Region	%	City	%
Total:	32,621		33,571	
Wages	7,700	23.6	8,534	25.42
Social Security	3,045	9.33	3,362	10.01
Pharmaceuticals	3,767	11.54	3,571	10.63
Equipment	4,692	14.38	4,901	14.59
Food	4,816	14.76	4,772	14.21
Utilities	5,973	18.31	5,648	16.82
R&M	1,425	4.36	1,881	5.60
Disposable supplies	275	0.83	249	0.74
Other	739	2.2	653	1.94

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Note 1. Capitation - The Financial Mechanism of the System

1. In the enactment of Supreme Soviet of RF "On the Procedure of Financing of Compulsory Health Insurance in 1993", it states:

   "Territorial CMI funds should finance CMI programs which are carried out by the health insurance companies on the basis of applying differentiated capitated norms which are established by Fund Board of Administration."

2. This was followed up by the Government decree of Oct. 11, 1993 (Council of Ministers 1993) that states in its second item:

   "The Federal CMI Fund (FCMIF) shall:

   a) in consultation with the Ministry of Health of the RF and the Ministry of Finance of the RF, prior to November 1, 1993, approve procedures for determining average per capital rates of financing the territorial CMI programs;

   b) in consultation with the Federal Service of Russia for Supervision over Insurance Activities, prior to November 1, 1993, approve standard CMI Rules and a format for a standard agreement between TFCMI and an insurance medical agency."

3. In addition, the decree stipulates in its fourth item:

   "The Ministry of Health of the Russian Federation shall:

   a) develop, in preparing a 1994 budget, and submit to the Council of Ministers, Government of the Russian Federation proposals on procedures for financing medical institution which are not part of the system of the Ministry of Health of the as well as medical institutions of the Federal level which are under the Ministry health of the RF;

b) in consultation with the Ministry of Finance, FCMIF, prior to December 1, 1993, approve settlement procedures between health authorities and territorial CMI-funds for provision of the medical care under CMI.

4. Capitation is thus stipulated as the key financial mechanism for the health system. Indeed, capitation fits well the reform philosophy of the Russian reform efforts aiming at fostering a competitive environment with minimum government involvement in the organization and management of care provision, and in establishing the scope of choice available to consumers, yet under public finance principles.

5. The definition of capitation and its implementation therefore must encapsulate several basic issues most of which are stipulated by the October 1993 decree of GRF.

Note 2: Wage-bill Determined Health Budget

Suppose that the health budget, either at the regional or national level, is denoted as follows:

$$H = E + B \tag{1}$$

where:

H = total health budget,
E = health tax revenues from wage-bill, and
B = general revenues allocated to health.

The health tax is determined as follows:

$$E = pWN \tag{2}$$

where:

p = the health tax rate on the wage bill,
W = the (average) wage rate, and
N = the number employed.

In a capitation system based on the premise that employers finance the employed population, the allocation to each person (C) is determined as follows:

$$C^* = E/N^* \quad (3)$$

Where C* is the standard capitation level for the standardized number of employed N*. These variables follow from the common practice to allow persons of, primarily age and sex, profiles to have different **relative** capitation coefficients.

Note 3: Medical specialties by which the basic program was established.

1. Cardiology
2. Rheumatology
3. Gastroenterology
4. Pulmonology
5. Endocrinology
6. Nephrology
7. Hematology
8. Allergology
9. Pediatric (somatic)
10. General therapy
11. Infection diseases
12. Neonatology
13. Traumatology
14. Orthopedic
15. Urology
16. Neurosurgery
17. Trauma from burn
18. Stomatology
19. Thoracic surgery
20. Proctology
21. Cardio surgery
22. Vascular surgery
23. General surgery
24. Oncology
25. Obstetrics and Gynecology
26. Otolaryngology
27. Ophthalmology
28. Neurology
29. Dermatology

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Note 4: The basic program for 1993 included:

a. polyclinic care (primary care, diagnostic and treatment in policlinic, emergency care, preventive care) in volume of 8 visits to physicians in an year per capita;

b. hospital care by medical referral in volume of 230,0 hospitalizations in a year per 10 000 of population in all types of hospitals. Calculated need in hospital beds will comprise 97.06 beds per 10,000 population and beds for social nursing it will comprise 109.44 beds.

The basic program is oriented to intensive utilization of resources, structural optimization of the medical facilities net both for the profile of beds and types of visits.

Cost accounting of the basic program is based on a study of the medical care needs and expenditures per "one medical service" (a visit, a hospitalization, etc.) taking into the account the indexation.

Inputs

(a) Polyclinic care

(1) Its expenditures (prices for December 1992) were 625.14 milliard rubles.

(2) Cost of one visit - 469 rubles

(3) Annual expenditures for one citizen - 4516.8 rubles (including 3858.5 rbl. per one men and 4516.8 rbl. per one woman)

(a) Hospital care

(4) Its expenditures (prices for December 1992) were 727.33 milliard rubles

(5) Cost of one bed per one year - 450 thsn. rbl.

(6) Cost of hospitalization of one patient - 19.86 thsn. rbl.

(7) Annual expenditures per one citizen - 4903.6 rbl. (including 4814.4 rbl. per one men and 4982.5 rbl. per one woman)

Note 5: The Capitation Formula for Health Funds Allocation

1. The formula is a follows:

$$N_i = \frac{N_{1992}}{\sum_i (t_i * \vee SMR_i) * \sum_j (P_{ij} * C_j)} * \vee SMR_i * t_i * \sum_j (P_{ij} * C_j) \qquad (1)$$

where:

N_i -	need-based health expenditures in oblast i; 15
N_{1992} -	1990-level local health expenditures in the Russian Federation in 1992;
SMR_i -	Standardized mortality rate in oblast i;
P_{ij} -	population in age group j in oblast i;
C_j -	age cost coefficient for age group j;
t_i -	regional cost coefficient in oblast i

1990 - level health expenditures for 1992 were computed by applying 1992 age and-gender structure and 1992/90 consumer price index to the 1990 health expenditures:

$$N_{1992} = N_{1990} / \sum_j [C_j * P_{1990j}] * \sum_j [C_j * P_{1992j}] * INDEX \qquad (2)$$

where:

N_{1990} -	actual local health expenditures in 1990;
INDEX-	1992/1990 consumer price index.

2. THREE SCENARIOS FOR FORMATION OF LOCAL HEALTH BUDGETS.

Actual health funds of each oblast is formed as follows:

$$H_i = T_i + B_i \qquad (3)$$

where:

H_i -	actual health funds in oblast i;
T_i -	wage bill health tax in oblast i;
B_i -	health funds allocated by the local budget in oblast i.

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Wage bill health tax by oblast, Tj, was calculated as 3.4~ of oblast wage bill. No displacement value was applied.

$$Tj = 0.034 * WBj \quad (4)$$

where:

WB_i - wage bill in oblast i.

We assume that the Federal budget would subsidy those oblast, which actual health budget is lower than the estimated need-based one.

$$S_i = N_i - H_i, \text{ if } N_i > H_i$$
$$0, \text{ if } N_i <= H_i \quad (5)$$

where:

S_i - Federal health subsidy to oblast i.

a. <u>First allocation scenario</u>

The first scenario for local health financing suggests that local budget allocates the same age-adjusted sum of money for non-employed that is provided to the employed by the wage bill health tax.

$$B^1_j = T_i * \sum_j [C_j * (P_{ij} - EP_{ij} + CH_{ij})] / \sum_j [C_j * (EP_j - Ch_{ij})] \quad (6)$$

where:

EP_{ij} - employed population in age j in oblast i;
CH_{ij} - women with children in age up to three years old in oblast 1; applicable to age 16-54 only, for other ages equal to o.

b. Second allocation scenario

The second scenario of local health financing suggests that the local budget allocates for health the same percentage of oblast gross product (GP), that N_{1900} formed in GP_{1990}:

$$B^2_i = GP_{1992,i} * N_{1990} / GP_{1990} \quad (7)$$

where:

GP_i - economic potential of oblast i.

c. Third allocation scenario

1992/90 index of national global economic indicators (in actual prices) is higher than the 1992/90 consumer price index (which is equal to 23 times), used as health services price index: GDP92~90 = 27, NMP92~90 = 33, GP92~90 = 27. Thus, national economy, in general, can provide the 1990 level of health expenditures. The third scenario of health financing suggests that local health budget allocates money in the amount, needed in addition to the wage bill health tax up to the 1990-level percent of GP:

$$B^3_i = (GP_{1992,i} * N_{1990} / GP_{1990}) - T_i \quad (8)$$

Note 6: The Data

1. DATA

a. Population, total and by age-and-gender groups, by oblast, 1992; national, 1990, 1992. The following age structure is available by oblast: "0 15", "16-pension age" and, "older than pension age". The pension age is 54 for females and 59 for males. National data are available by detailed age and gender structure (both genders, every 5 years).

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b. Women-employees with children under 3 years old, by oblast, 1992. This data is not available. The number of children under 3 years old in oblast i was estimated as follows:

$$CH_i = \sum_{j=1990-1992} P_{ij} * NT_{ij} * (1 - IM_{ij}) \quad (9)$$

where:

CH_i - number of children under 3 years old;
P_{ij} - population in oblast i in year j (Goskomstat, 1992a; Goskomstat, 1993a);
NT_{ij} - natality in oblast i in year j (Goskomstat, 1992a; Goskomstat, 1993a);
IM_{ij} - infant mortality in oblast i in year j (Goskomstat, 1992b; Goskomstat, 1993b);

c. Employed population, total and by age-and gender groups, by oblast, 1992. Only the total number of the employed is available by oblast (Goskomstat, 1993c). National age structure was applied for all oblasts (Goskomstat, 1993a). The same age structure ('0-15', '16-pension age', and 'older than pension age') was used:

0-15	.28%
16-54(59)	93.35%
55(60)+	6.37%

d. Standardized Mortality Rates (SMR), by oblast, 1992. 1992 data were not available. 1989 data on age-and-gender mortality rates were used ('MedSocEconomInform').

$$SMR_i = \sum_j d_{ij} / \sum_j (P_{ij} * \sum_j d_{ij} / \sum_j P_{ij}) \quad (10)$$

where:

MR_i- Standardized mortality rate in oblast i;
d_{ij} - death cases In age-and-gender group j in oblast i;
P_{ij} - population in age-and-gender group j in oblast i.

e. Age-and-gender cost coefficients for medical services. The FMOH recommended cost coefficients were weighted by the 1992 national age-and gender structure of the population

and aggregated according to the available oblast-level age structure (Ministry of Health of the USSR, 1989):

age	cost coefficient
'0-15'	3.94
'16-54(59)'	3.82
'55(60)+'	9.14

f. Oblast price coefficient for medical services, 1992. Data are not available. Data on the cost of main foodstuffs' set by economic regions were used (Federal Center for Economic Analysis and Forecast, 1993).

g. Local health expenditures, 1990, 1992. These data are available (Federal Ministry of Health working tables).

N_{1990} = 13,112.9 mln. rbs.

h. 1992/90 price index of medical services. The index is not available, the 1992/90 consumer price index was applied (Goskomstat, 1992a; Goskomstat, 1993a):

INDEX = 22.99 times

i. Wage bill, by oblast, 1992. Data on wage bill are not available. They were estimated as follows:

$$WB_i = 12 * (EP_i - CH_i) * W_i \quad (11)$$

where:

WB_i - wage bill in oblast i;
EP_i - employed population in oblast i (Goskomstat, 1993c);
W_i - average monthly wage of employees in oblast i (Goskomstat, 1993b).

It was assumed that all other categories of the employed (farmers, self employed, etc.) got the same

average wages. Women with small children are not assigned wages, although they are included in staff lists.

j. GDP or NMP, by oblast, 1992; national, 1990. Oblast-level data are not available. Estimate of oblast gross production (GP) was calculated for 1990 and 1992 as follows:

$$GP_i = IP_i + AP_i + PS_i \tag{12}$$

where:

IP_i - gross industrial product in oblast i (Goskomstat, 1993c);
AP_i - gross agricultural production in oblast i (Goskomstat working tables);
PS_i - volume of paid services in oblast i (Goskomstat, 1993a).

1992 oblast-level data on AP are available only in 1983-level prices. They were adjusted according to the national actual-price AP (Goskomstat, 1993a).

k. Annual average exchange rate, 1992. It was estimated as the harmonic average from the data on the exchange rates in the beginning and the end of each month in 1992 (Federal Center for Economic Analysis and Forecast, 1993).

$$\text{EXCHANGE RATE}_{1992} = 209.4 \text{ rubles per 1 USD}$$

2. DATA SOURCES

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ПРИЛОЖЕНИЕ III
СПРАВОЧНЫЕ ТАБЛИЦЫ

Таблица 1
Здоровье населения

Продолжительность жизни	1990	1991	1992	1993
Мужчины	63.8	63.5	62	60.0
Женщины	74.3	74.3	73.8	72.5
Уровень смертности (на 1000 населения)		11.4	12.2	14.5
Детская смертность (на 10000 родившихся)		178.2	180.5	199
Уровень рождаемости(на 1000 населения)	13.4	12.1	10.8	9.4
Количество абортов (на 100 родившихся, включая мертворожденных)	200.8	205.6	207	

Источник: PJP Publications Ltd, Отчеты SCRIP, август 1993, стр.198, Госкомстат, Статистическое управление

Таблица 2
Ресурсы медицинских учреждений

	1990	1991	1992	1993	ОЭС 1990
Больницы (тыс.)	12.8	12.7	12.6	12.5	
Койки (тыс.)	2,037.6	1,998.7	1,898.8	1,890	
Койки (на 10,000 населения)	137.5	134.7	127.7	126.8	90.1
Поликлиники (тыс.)	21.5	20.8	20.0		
Количество приемов за смену (тыс.)	3,222	3,272	3,321	3,322	
Количество приемов за смену (на 10,000 населения)	217	221	224	224	

Источник: Госкомстат, 1992 Медицинское обслуживание населения в РФ, Статистическое управление

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[1]"Количество приемов за смену" это показатель мощности поликлиники, который показывает максимальное количество пациентов, которых способна обслужить поликлиника при условии полной укомплектованности штата. Данный показатель используется в статистике Российского здравоохранения.

Таблица 3
Состояние зданий эксплуатируемых больниц и поликлиник в 1988 г.

Состояние	Больниц	Поликлиник
В ужасающем состоянии	9%	5%
Требующие капитального ремонта	14%	14%
Требующие ремонта	32%	30%
Требующие небольшого ремонта	30%	34%
В хорошем состоянии	15%	17%
Итого	100%	100%

Источник: Отчет Всемирного Банка,*Реформа сектора здравоохранения России:Перспектива финансов здравоохранения*, декабрь 1993 на основе книги Госкомстата, 1989 Статистика Здравоохранения

Таблица 4
Состояние эксплуатируемых поликлиник и больниц в 1988

Здания без:		
Канализации	24%	15%
Центрального отопления	19%	12%
Ванны/Душа	45%	52%
Электричества	1%	1%

Источник: Отчет Всемирного Банка,*Реформа Здравоохранения России:Перспектива финансов здравоохранения*, декабрь 1993 на основе книги Госкомстата, 1989 Статистика Здравоохранения

Таблица 5
Строительство новых мощностей

	1985	1991	1992	92/91
Новые больничные мощности (койки)	31,441	17,426	8,151	47%
Новые мощности поликлиник (к.приемов в смену)	76,340	62,508	39,636	63%

Источник:Госкомстат. *Медицинское обслуживание в Российской Федерации в 1992 г.*

Таблица 6
Человеческие ресурсы

	1990	1991	1992	1993
Количество врачей (тыс.)	694.7	657.6	662.8	663
Количество врачей (на 10,000 населения)	46.9	44.3	44.7	45
Количество среднего медицинского персонала (тыс)	1,816.7	1,691.1	1,684	1,680
Количество среднего медицинского персонала (на 10,000 населения)	122.5	114.1	113.6	113
Количество студентов-медиков (тыс.)		214	217	

Источник:Госкомстат, 1992 Медицинское обслуживание населения в РФ.

Таблица 7
Зарплата работников здравоохранения (Руб. в месяц)

Год	1991	1992	1993	1994/квартал
Средняя зарплата работников здравоохранения (руб.по текущ. курсу)	580	5,654	44,232	122,643
Индекс розничных цен	1.0	26.0	10.0	3.6
Средняя зарплата в здравоохранении (в руб 1991г.)	580	217	170	131
Сравнительное годовое увеличение		-167%	-28%	-30%

Источник: Госкомстат РФ, Отдел статистических публикаций

Таблица 8
Россия: Местное производство в 1992

Вид	Количество предприятий	в 1992, млрд руб.
Синтетические	11	16.4
Готовые лекарства	12	14.0
Витаминные препараты	7	10.9
Антибиотики	17	16.3
Вакцины	7	1.5
Гомеопатические препараты	2	0.8
Пластические	12	6.3
Медицинское оборудование	23	8.2
Итого	91	74.4

Таблица 9
Россия: Удовлетворение спроса в 1992-1993

%	1992		1993	
	Внутреннее приозводство	+ Импорт	Внутреннее приозводство	+Импорт
Сердечнососудистые	59	91	35	65
Психотропные	43	74	33	68
Противоопухолевые	45	75	22	70
Антибиотики	59	80	54	78
Анальгетики	29	90	31	88
Антисептики	85	94	41	47
Сульфонамиды	65	84	50	23
Кровозаменители	40	79	75	88

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Таблица 10
Оптовые продавцы фармацевтических препаратов

Страна	Склады		Аптеки/ Склады
	Количество складов	Средний объем продаж (миллионов $)	
Германия	105	152	172
Франция	227	66	97
Италия	353	28	45
Великобритания	65	115	183
Испания	189	32	95
В среднем по ЕС	нет данных	58	92
Венгрия	32	16	63
Россия (по оценкам)	133	3-25	120

Таблица 11

Страна	Общенациональные оптовые продавцы, торгующие полным ассортиментом продукции				Региональные оптовые продавцы, торгующие полным ассортиментом продукции			
	Количество комп.	Количество складов	Кол-во складов на комп.	% на рынке	Количество комп.	Количество складов	Кол-во складов на комп.	% на рынке
Германия	5	70	12.0	80	17	35	2.0	20
Франция	17	218	12.8	97	2	7	3.5	3
Великобр	2	39	19.5	70	24	27	1.2	30
Италия	8	120	15.0	50	100	160	1.6	50
Испания	3	60	20.0	30	82	140	1.7	70
Швеция	2	7	3.5	100	0	0	0.0	0
Швейцар	2	8	4.0	70	4	4	1.0	30
Венгрия	1	3	3.0	22	23	29	1.3	78
Россия*	3	5	1.7	<10%	100**	130	1.3	<90%

* По оценкам

** Если учитывать дилеров, работающих без складских помещений, количество оптовых продавцов увеличилось бы до 50-100.

Таблица 12

Страна	Аптека		Население/ аптека	Ассортимент	
	Кол-во (000)	Ср.кол-во продаж (тыс $)		Лекарства (000)	Итого (000)
Германия	18.1	884	3400	45.0	130.0
Франция	22.1	678	2600	7.0	20.0
Италия	16.0	625	3500	7.5	13.7
Великобрита ния	11.9	630	5000	7.0	11.0
Испания	18.0	333	2200	9.5	18.0
В среднем по ЕС	неприменим о	632	3300	17.0	38.0
Венгрия	1.9	333	5400	2.7	6.0
Польша	5.2	115	7300	12.0	непримен.
Россия	16	50-700	9400	2-3	непримен.

Таблица 13
Тенденции расходов правительства на здравоохранение с 1985 по 1993

Расходы	1987	1988	1989	1990	1991	1992	1993
Общие номинальные (млн., руб)	10,817	11,892	13,732	16,018	36,693	314,200	3,600,000
Общие реальные (млн., руб)	26,269	28,565	31,414	34,279	36,693	19,114	23,182
Рост общих рельных (%)	6	9	10	9	7	-92	21
Реальн. на душу населения (руб)	180	194	212	230	248	129	156
Рост затрат на душу населения (%)	5	8	9	8	6	-92	21

Источник: Отчет Всемирного Банка, *Реформа сектора здравоохранения: Перспективы финансов здравоохранения*, декабрь, 1993. Основано на анализе данных Института Медсоцэкономинформ, Москва. Информация за 1987-1991 года основана на данных Всемирного Банка, Российская Экономическая Реформа, 1992 и МВФ и ВБ, Экономика СССР, 1990. Сокращение составляет 0,408, 0,412, 0,437, 0,467, 1,0 для 1985 - 1990 г. Сокращение для 1992 и 1993(17,85 и 8.7) составлены из среднего показателя зарплаты в системе здравоохранения и розничными ценами, основаннными на данных Госкомстата и материалах книга Стародубова "Здоровье на рабочем месте", 31.05.94.

Таблица 14
Текущие расходы правительства на здравоохранение по категориям (%)

Рецепиент	1989	1990	1991
Больница	71.4	69.3	66.6
Амбулатория	9.1	8.9	9.5
Другие учреждения	5.3	8.1	11.8
Неотложная помощь	2.0	2.0	2.3
Центры переливания крови	1.0	0.9	0.8
Все учреждения	88.8	89.3	91.0
Общественное здравоохранение	3.1	3.1	3.2
Образование и исследования	5.7	4.9	2.2
Другие	2.4	2.7	3.6
Итого	100.0	100.0	100.0

a. включая 2.6 и 2.4 процента на Санатории в 1989 и 1990, соотвотственно. Также включает остаткиI ТМА после вычета платы ТМА больницам и учреждениям неотложной помощи. Большинстая чать остатка принадлежит амбулатории. Остаток ТМА составлял 5.6 and 9.3 процента в 1990 и 1991, соответственно. Источник:Отчет Всемирного Банка,*Реформа сектора здравоохранения России: Перспективы финансов*, декабрь, 1993

Таблица 15
Расходы бюджета здравоохранения в Российской Федерации, 1992

	Фактический бюджет 1992 г.					
	Бюджетная сводка		из которой:			
Индексатор бюджета	(млрд руб.)	%	Федеральный	%	Региональны	%
Затраты на здравоохранение	341.2	100	67.4	100	273.8	100
из которых:						
Зарплата	128.5	38	30.6	46	97.9	36
Поступления от социального страхования	48.8	14	11.6	17	37.2	13
Материальные затраты	163.9	48	25.2	37	138.7	51
Затраты бюджета здравоохранения на душу населения (000 руб)	2.3					
Доля здравоохранения в Государственном Бюджете (%)	6.2		1.7		16.8	
Доля здравоохранения в ВНП (%)	2.3					

Источник: PIP Publications, отчеты SCRIP, декабрь 1993, основано на Byudzhemoe Poslanie na 1992 God (1992), Byudzhemoe Poslanie na 1993 God (1993), стр. 397, и оценки.

Таблица 16
Уровни и распределение финансирования здравоохранения, 1989 - 1992

	1989	1990	1991
а. Система Минздрава Местный Федеральный	78.42 % 75.52 % 2.91 %	78.99 % 76.01 % 2.98 %	82.44 % 79.35 % 3.09 %
б. Параллельные системы	7.51 %	8.12 %	8.70 %
в. Частные	14.07 %	12.89 %	8.87 %
Итого, млн руб, % от ВНП	36.556 2.8	39,533 2.9	40,253 3.3

Источник: Отчет Всемирного Банка, *Реформа сектора здравоохранения в России*: Перспективы финансов здравоохранения, декабрь 1993.

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Таблица 17
Распределение частных расходов на здравоохранение, 1989 - 1992

	1989	1990	1991	1992
Взносы	16.36 %	16.37 %	18.64 %	16.35 %
Аптека и оптика	83.64 %	83.63 %	81.36 %	83.65 %
Частные, мин. руб.	5,141	5,095	3,670	3,009

Источник: Отчет Всемирного Банка, *Реформа сектора здравоохранения в России*: Перспективы финансов здравоохранения, декабрь 1993

Таблица 18

Таблица 18 суммирует некоторые характеристики каждой системы в 1990 г., до недавних крупных изменений в России. Обратите внимание на то, что в 1993 г. по оценкам российский официальных лиц расходы черного рынка на здравоохранение могли составить примерно 25% от общих расходов.

Страна	Расходы здравоохранения на душу населения	% Здравоохранения от ВНП	Вид системы	% Общественного финансирования
Россия 1990	121 1	2.9 2	налог.финанс.	80 - 95 3
Россия 1993	31 1	>3.0 3	переходн.	<75 3
В среднем по ОЭС	1204	7.6	-	74
Нидерланды	1286	8.2	слабые фонды	71
Германия	1486	8.1	слабые фонды	73
Великобритан.	972	6.2	налог.финанс.	84
Швеция	1451	8.6	налог.финанс.	90
США	2566	12.1	налог +страх.	42

Источник: Финансовое обозрение здравоохранения 1992

Источник (Россия): 1 оценки BCG 2 Всемирный банк, декабрь, 1993 3 Неопубликованные данные Министерства здравоохранения, Госкомстата

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Таблица 19

Источник финансирования	1991	1992
Акт фонда медицинского страхования	32.9	23.9
Акт исключительных медицинских расходов	31.4	45.6
Правительство	10.6	10.7
Другие источники	25.0	19.9

Источник: FOZ 1992

Таблица 20
Сравнительные результаты медицинского обслуживания в России и 5 странах ОЭС (1990)

Страна	Мужская продолжительн ость жизни	Женская продолжительн ость жизни	Детская смертность (Смерти/1,000)	Чистый уровень рождаемости (на 1,000)
Россия 1990	63.9	74.3	17.4	13.4
Россия 1993	60.0	72.5	-	9.4
ОЭС в среднем	72.6	78.9	7.4	13.0
Нидерланды	73.8	80.1	7.1	13.2
Германия	72.6	79.0	7.5	11.3
Великобр.	72.8	78.5	7.9	13.9
Швеция	74.8	80.4	6.0	14.5
США	72.0	78.8	9.1	16.7

Источник: Обзор финансирования здравоохранения 1992
Источник (Россия): 1990 Неопубликованные данные Министерства здравоохранения; 1993 Госкомстат

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Таблица 21
Разница между реальными и требуемыми затратами на здравоохранение в 1992 году.

ТЕРРИТОРИЯ	МЕСТНЫЕ РАСХОДЫ НА ЗДРАВООХРАНЕНИЕ		
	РЕАЛЬНЫЕ В МЛН. РУБЛ.	ТРЕБУЕМЫЕ В МЛН. РУБЛ.	РАЗНИЦА %
РОССИЯ	413,789.0	302,862.5	36.63
СЕВЕРНЫЙ РЕГИОН			
Карельская республ.	2,941.4	1,896.5	55.09
Республика КОМИ	5,300.6	2,806.3	88.88
Архангельская обл.	4,887.4	3,613.2	35.27
Вологодская обл.	3,932.5	3,321.7	18.39
Мурманская обл.	5,810.5	2,288.0	153.95
СЕВЕРО-ЗАПАДНЫЙ РЕГИОН			
Санкт-Петербург	11,558.2	10,938.8	5.66
Ленинградская обл.	4,363.0	3,765.5	15.87
Новгородская обл.	1,885.6	1,759.5	7.17
Псковская обл.	1,963.8	1,988.6	-1.25
ЦЕНТРАЛЬНЫЙ РЕГИОН			
Брянская обл.	2,801.7	3,037.2	-7.75
Владимирская обл.	3,788.8	3,498.9	8.28
Ивановская обл.	2,993.9	2,845.1	5.23
Калужская обл.	2,002.5	2,281.5	-12.23
Костромская обл.	1,883.9	1,725.8	9.16
Москва	29,127.8	20,618.5	41.27
Московская обл.	13,759.8	14,193.4	-3.06
Орловская обл.	1,756.2	1,905.8	-7.85
Рязанская обл.	3,289.0	2,856.7	15.13
Смоленская обл.	2,053.6	2,461.9	-16.58
Тверская обл.	2,994.5	3,659.8	-18.18

ТЕРРИТОРИЯ	МЕСТНЫЕ РАСХОДЫ НА ЗДРАВООХРАНЕНИЕ		
	РЕАЛЬНЫЕ В МЛН. РУБЛ.	ТРЕБУЕМЫЕ В МЛН. РУБЛ.	РАЗНИЦА %
Тульская обл.	4,076.6	4,083.5	-0.17
Ярославская обл.	3,580.2	3,061.1	16.96
ВОЛГО-ВЯТСКИЙ РАЙОН			
Республика Мари-Эл	2,147.5	1,351.5	58.90
Республика Мордовия	2,393.2	1,689.3	41.66
Чувашия	3,150.3	2,349.3	34.09
Кировская обл.	4,096.4	3,100.6	32.12
Нижегородская обл.	8,492.8	6,964.5	21.94
ЦЕНТРАЛЬНО-ЧЕРНОЗЕМНЫЙ РАЙОН			
Белгородская обл.	3,186.3	2,474.4	28.77
Воронежская обл.	5,572.7	4,444.4	25.39
Курская обл.	2,707.7	2,478.6	9.24
Липецкая обл.	3,386.8	2,191.4	54.55
Тамбовская обл.	2,786.1	2,414.1	15.41
ПОВОЛЖСКИЙ РАЙОН			
Республика Калмыкия	868.2	515.8	68.32
Республика Татария	10,912.4	5,756.4	89.57
Астраханская обл.	2,027.7	1,637.1	23.86
Волгоградская обл.	5,792.8	4,330.1	33.78
Пензенская обл.	2,820.2	2,455.2	14.87
Самарская обл.	8,872.7	5,300.4	67.40
Саратовская обл.	5,794.8	4,419.2	31.13
Ульяновская обл.	3,458.2	2,356.7	46.74
СЕВЕРО-КАВКАЗСКИЙ РЕГИОН			
Республика Адыгея	876.0	912.1	-3.96
Республика Дагестан	2,870.5	2,717.9	5.61

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ТЕРРИТОРИЯ	МЕСТНЫЕ РАСХОДЫ НА ЗДРАВООХРАНЕНИЕ		
	РЕАЛЬНЫЕ В МЛН. РУБЛ.	ТРЕБУЕМЫЕ В МЛН. РУБЛ.	РАЗНИЦА %
Республика Кабардино-Балкария	1,567.7	1,437.7	9.04
Карачаево-Черкесская респ.	801.1	832.9	-3.82
Респ. Северная Осетия	1,411.4	1,206.1	17.02
Краснодарский край	9,637.2	10,063.3	-4.23
Ставропольский край	3,939.0	5,109.9	-22.91
Ростовская обл.	8,380.0	8,863.8	-5.46
УРАЛ			
Республика Башкирия	14,993.3	7,753.3	93.38
Республика Удмуртия	3,787.1	3,207.7	18.06
Курганская обл.	2,642.1	2,243.2	17.79
Оренбургская обл.	6,251.1	4,271.1	46.36
Пермская обл.	9,550.6	6,229.8	53.31
Свердловская обл.	16,916.4	9,438.4	79.23
Челябинская обл.	13,998.9	7,240.8	93.33
ЗАПАДНО-СИБИРСКИЙ РЕГИОН			
Горный Алтай	645.2	458.6	40.71
Алтайский край	6,537.4	6,424.0	1.77
Кемеровская обл.	12,292.7	6,768.8	81.61
Новосибирская обл.	5,404.5	5,817.8	-7.10
Омская обл.	6,642.9	4,402.7	50.88
Томская обл.	2,747.1	2,053.3	33.79
Тюменская обл.	18,690.1	5,657.9	230.34
ВОСТОЧНО-СИБИРСКИЙ РЕГИОН			
Республика Бурятия	2,779.7	2,080.8	33.59
Республика Тува	1,257.8	674.1	86.59
Республика Хакассия	1,536.3	1,186.9	29.44

ТЕРРИТОРИЯ	МЕСТНЫЕ РАСХОДЫ НА ЗДРАВООХРАНЕНИЕ		
	РЕАЛЬНЫЕ В МЛН. РУБЛ.	ТРЕБУЕМЫЕ В МЛН. РУБЛ.	РАЗНИЦА %
Красноярский край	12,269.3	6,060.2	102.46
Иркутская обл.	9,009.0	5,766.0	56.24
Читинская обл.	3,718.7	2,691.9	38.15
ДАЛЬНЕВОСТОЧНЫЙ РЕГИОН			
Респ. Якутия-Саха	9,174.6	2,828.6	224.35
Приморский край	6,485.6	6,488.0	-0.04
Хабаровский край	6,864.6	5,696.3	20.51
Амурская обл.	2,865.4	2,898.7	-1.15
Камчатская обл.	2,498.3	1,169.6	113.60
Магаданская обл.	3,623.6	1,040.0	248.41
Сахалинская обл.	3,829.0	1,969.3	94.43
Калининградская обл.	1,863.6	1,936.6	-3.77

Таблица 22
Разница между реальными и требуемыми фондами здравоохранения в зависимости от применяемого варианта ассигнований, в млн. долл. США

ТЕРРИТОРИЯ	Первый Вариант	Второй Вариант	Третий Вариант
РОССИЙСКАЯ ФЕДЕРАЦИЯ	513.6	932.9	141.7
СЕВЕРНЫЙ РЕГИОН			
Республика Карелия	3.5	4.4	-0.9
Республика КОМИ	17.4	14.1	0.1
Архангельская обл.	8.2	5.0	-5.1
Вологодская обл.	4.7	12.0	4.4
Мурманская обл.	14.6	19.3	7.7
СЕВЕРО-ЗАПАДНЫЙ РЕГИОН			
Санкт-Петербург	4.6	0.3	-22.0
Ленинградская обл.	2.7	9.5	2.3
Новгородская обл.	0.2	0.8	-2.6
Псковская обл.	-1.0	-0.5	-3.6
ЦЕНТРАЛЬНЫЙ РЕГИОН			
Брянская обл.	0.2	1.8	-3.6
Владимирская обл.	2.4	10.3	2.7
Ивановская обл.	0.7	8.1	2.7
Калужская обл.	-0.4	-0.3	-4.3
Костромская обл.	1.0	1.8	-1.7
Москва	18.3	14.3	-37.1
Московская обл.	8.6	8.8	-15.9
Орловская обл.	0.2	3.4	-0.2
Рязанская обл.	0.7	9.8	4.2
Смоленская обл.	1.1	5.1	0.2
Тверская обл.	1.4	2.4	-4.4
Тульская обл.	4.3	9.7	0.5

Схема I
Уровень смертности от заболеваний (на 100,000 жителей) в 1992г.

	Сердечно-сосудистые	Рак	Несчастные случаи и отравления	Инфекции дыхательных путей	Расстройство пищеварения
Российская Федерация	646.0	201.8	173.0	57.9	32.8
Северный регион	564.1	166.5	199.0	41.8	25.0
Северо-Запад	790.3	267.0	200.8	46.0	38.5
Центральный	785.5	248.9	169.4	54.0	36.8
Волго-Вятский	685.7	189.5	175.2	81.8	28.0
Центрально-Черноземный	788.8	208.1	142.2	89.7	34.6
Поволжье	643.5	206.8	143.5	46.7	31.1
Северный Кавказ	650.2	180.2	122.4	56.6	35.6
Урал	606.8	185.2	184.3	68.6	29.5
Западная Сибирь	497.6	179.3	192.7	55.8	29.8
Восточная Сибирь	480.6	165.5	217.8	64.1	36.0
Дальний Восток	455.9	151.2	214.1	39.1	28.9

Источник: Госкомстат, 1992 Медицинское обслуживание населения РФ.

Схема II
10 основных заболеваний в 1992 (на 1,000 жителей)

	Всего заболеваний	Инфекционные заболевания	Заболевания нервной системы	Сердечно-сосудистые	Дыхательная система	Расстройство пищеварения	Истощение	Осложнения беременности	Кожные заболевания	Болезни опорно-двигат	Травмы и отравления
РФ	615.6	34.9	50.6	11.5	289.7	31.2	22.3	34.9	35.7	25.6	82.9
Северный регион	679.7	45.6	46.0	9.1	305.5	20.4	21.0	33.8	37.0	28.3	85.9
Северо-Запад	607.2	40.9	38.2	8.1	308.9	18.6	16.9	20.8	35.9	17.9	95.7
Центральный	621.0	33.0	47.5	11.2	317.8	22.8	25.0	29.0	32.9	24.9	80.3
Волго-Вятский	629.7	32.5	56.5	12.7	263.6	62.2	23.0	36.7	31.8	29.7	84.5
Центрально-Черноземный	532.7	29.5	48.3	12.5	239.5	22.3	20.5	29.1	34.3	27.4	69.0
Поволжье	618.9	33.8	54.7	13.5	282.8	31.5	21.8	34.5	37.5	29.4	81.0
Северный Кавказ	514.1	27.5	47.7	13.0	220.7	29.4	23.2	27.3	35.6	21.0	69.0
Урал	646.3	36.5	54.8	11.2	296.5	36.9	21.8	50.8	35.7	21.0	69.0
Западная Сибирь	681.5	40.9	57.4	12.6	305.3	37.6	29.5	41.5	41.4	29.0	93.0
Восточная Сибирь	587.8	34.3	48.4	9.5	275.3	36.2	21.8	34.1	30.5	21.6	80.0
Дальний Восток	673.0	39.7	51.2	9.2	331.2	31.9	25.2	40.1	44.0	24.2	83.0

Схема III
Динамика заболеваний (на 100,000 жителей)

	Раковые заболевания			Грипп и респираторные			Вирусный гепатит			Корь		
	1985	1991	1992	1985	1991	1992	1985	1991	1992	1985	1991	1992
РФ	248	266	272	30,312	27,754	20,816	227	192	136	130.5	13.8	1
Северный регион	206	225	229	32,469	34,567	26,519	296	206	165	122.7	1.9	4
Северо-Запад	301	315	324	38,712	35,466	23,798	171	160	160	46.3	7.6	1
Центральный	282	305	309	39,016	34,678	23,520	165	112	87	122.4	19.0	2
Волго-Вятский	248	279	289	27,812	26,728	19,006	210	230	162	81.5	10.2	9
Центрально-Черноземный	266	308	308	23,071	21,829	17,465	168	167	146	56.9	30.3	1
Поволжье	260	273	279	28,503	24,540	19,599	210	152	113	88.8	18.0	
Северный Кавказ	252	262	261	22,802	18,141	14,798	249	273	172	102.1	21.6	1
Урал	239	252	266	28,630	26,941	21,260	208	199	132	100.2	5.6	
Западная Сибирь	222	237	266	29,200	26,996	21,405	211	241	139	285.3	5.1	1

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	Раковые заболевания			Грипп и респираторные			Вирусный гепатит			Корь		
Восточная Сибирь	183	206	207	23,923	23,928	19,278	397	268	181	271.6	8.7	
Дальний Восток	179	195	208	28,237	30,338	23,821	414	215	159	166.3	16.6	

Источник: Госкомстат, 1992 Медицинское обслуживание населения в РФ.

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Схема IV
Количество дней нетрудоспособности по болезни на каждого работающего за год

	1985	1991	1992	%92/91
РФ	11.6	11.4	10.6	0.92
Северный регион	11.8	13.2	12.3	0.92
Северо-Запад	12.4	13.1	11.2	0.85
Центральный	13.7	12.6	11.3	0.89
Волго-Вятский	10.9	12.1	10.2	0.84
Центрально-Черноземный	11.3	12.4	10.9	0.87
Поволжье	10.8	11.7	11.6	0.90
Северный Кавказ	0.9	0.9	0.8	0.833
Урал	11.6	0.9	10.4	1.10
Западная Сибирь	11.0	10.5	10.9	1.04
Восточная Сибирь	11.6	12.3	11.2	0.91
Дальний Восток	11.8	12.8	10.9	0.84

Источник: Госкомстат, 1992 Медицинское обслуживание населения РФ.

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Схема V
Врачи и медицинский персонал (на 10,000 жителей)

	Врачи			Медицинский персонал		
	1985	1991	1992	1985	1991	1992
РФ	45.1	44.3	44.7	120.6	14.1	113.6
Северный регион	41.8	42.5	43.1	141.9	139.9	137.6
Северо-Запад	66.0	54.6	55.2	134.3	108.9	109.1
Центральный	58.2	51.7	51.3	130.9	114.7	114.5
Волго-Вятский	35.5	38.1	39.7	111.5	109.8	108.7
Центрально-Черноземный	34.7	36.6	37.7	109.1	106.2	110.5
Поволжье	40.9	43.0	43.8	116.5	115.1	113.1
Северный Кавказ	40.4	41.8	41.6	108.8	111.3	108.2
Урал	37.0	38.8	39.5	115.6	114.4	116.1
Западная Сибирь	41.7	43.8	43.5	119.4	114.7	112.7
Восточная Сибирь	38.4	39.9	41.7	111.8	110.2	111.1
Дальний Восток	46.9	50.7	50.8	120.6	115.4	116.1

Источник: Госкомстат, 1992 Медицинское обслуживание населения РФ.

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Схема VI
Пермская область
Бюджет здравоохранения в 1993 году (млн.рубл.)

	Область	%
Зарплата	25,001	26.0
Социальные расходы	8,834	10.0
Лекарственные препараты	8,240	9.0
Оборудование	8,926	10.0
Питание	7,355	8.0
Предметы ухода за больными	11,265	12.0
Ремонт и содержание	6,856	7.0
Капитальные вложения	4,302	4.0

Схема VII
Тверская область
Бюджет здравоохранения в 1993 году (млн.рубл.)

	Область	%	Город	%
Всего:	32,621		33,571	
Зарплата	7,700	23.6	8,534	25.42
Социальные расходы	3,045	9.33	3,362	10.01
Лекарственные препараты	3,767	11.54	3,571	10.63
Оборудование	4,692	14.38	4,901	14.59
Питание	4,816	14.76	4,772	14.21
Предметы по уходу	5,973	18.31	5,648	16.82

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Ремонт и содержание	1,425	4.36	1,881	5.60
Одноразовые предметы	275	0.83	249	0.74
Другое	739	2.2	653	1.94

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Примечание 1. Исчисление "на душу населения" - финансовый механизм системы

1. В указе Верховного Совета РФ "О процедуре финансирования обязательного медицинского страхования в 1993 г." говорится:

"Территориальные фонды обязательного медицинского страхования д о л ж н ы финансировать программы ОМС осуществляемые медицинскими страховыми компаниями на основе применения дифференцированных "душеывх" норм, установленных с о в е т о м администрации фонда."

2. Далее последовал указ Правительства от 11 октября 1993 года (Совет Министров 1993) который определяет слудующие пункты:

"Федеральный фонд ОМС (ФФОМС) должен:

а) совместно с Министерством Здравоохранения РФ и Министерством финансов РФ в период до 1 ноября 1993 г. принять процедуры определения ставок на душу населения для финансировния территориториалных программ обязательного медицинского страхования;

б) совместно с Федеральной службой надзора над страховой деятельностью России в период до 1 ноября 1993 года, принять стандартные правила обязательного медицинского страхования, а также форму стандартного соглашения между ФФОМС и страховым медицинским агенством."

3. Также в четвертом пункте указ определяет следующее:

"Министерство Здравоохранения Российской Федерации должно:

а) развивать, подготавливая бюджет 1994 года, и представить в Совет Министров правительства Российской Федерации предложения о процедуре финансировния медицинских институтов, которые не являются частью системы Министерства Здравоохранения, а также медицинских учреждений федерального уровня, которые находятся в подчинении Министерства Здравоохранения РФ;

б) совместно с Министерством Финансов, ФФОМС, в период до 1 декабря 1993 года, принять процедуры урегулирования между администрацией здравоохранения и территориальными фондами ОМС для обеспечения медицинского обслуживаиня в системе ОМС".

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4. Таким образом, подход "на душу населения" определен как ключевой в финансовым механизме системы здравоохранения. На самом деле этот принцип хорошо вписывается в российскую философию реформ, усилия которой направлены на создание благоприятной обстановки с минимальным участием правительства в организации и управлении здравоохранением, а также на предоставление потребителям широкой возможности выбора, даже применительно к принципам общественного финансирования.

5. Тем не менее, определение подхода "на душу населения" и его применение должно включать несколько основных пунктов, большая часть которых была определена в указе правительства РФ от октября 1993 года.

Примечание 2: Доходы с налога на зарплату определяют бюджет здравоохранения

Предположим, что бюджет здравоохранения (регионального или национального уровня) можно представить сдедующей формулой:

$$H = E+B, \qquad (1)$$

где:

H= общий бюджет здравоохранения

E = годовой доход здравоохранения от налога на заработную плату

B= общий годовой доход ассигновнный здравоохранению

Тогда, налог на здравоохранение определяется следующим образом:

$$E = pWN, \qquad (2)$$

где

p = уровень налога на здравоохранения на з/плату

W = средний уровень зарплаты

N = количество служащих

В системе "на душу населения", основанной на предпосылке того, что работодатель финансирует население, нанятое на работу, ассигнования каждому коткретному человеку (C) будут рассчитываться следующим образом:

$C^* = E/N^*$

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Где C* стандартный "душевой" уровень для стандартизированного количества служащих N*. Эти переменные применяются в общей практике для того, чтобы люди, в первую очередь, различного пола и возраста, соответствовали разному "душевому" коэффициенту.

Примечание 3: Медицинские специальности, для которых были созданы основные программы.

1. Кардиология
2. Ревматология
3. Гастроэнтерология
4. Пульмонология
5. Эндокринология
6. Нефрология
7. Гематология
8. Аллергология
9. Педиатрия (соматическая)
10. Общая терапия
11. Инфекционные болезни
12. Неонатология
13. Травматология
14. Ортопедия
15. Урология
16. Нейрохирургия
17. Врожденная травма
18. Стоматология
19. Торакальная хирургия
20. Проктология
21. Кардио хирургия
22. Сосудистая хирургия
23. Общая хирургия
24. Онкология
25. Акушерство и гинекология
26. Отоларингология
27. Офтальмология
28. Неврология
29. Дерматология

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а. поликлиническое обслуживание (первая помощь, диагностика **Приложение 4: Основная программа на 1993 год включает:**

и лечение в поликлинике, неотложная помощь, профилактическая помощь) в объеме 8 посещений врача в год на душу населения;

б. стационарное обслуживание в объеме 230,0 госпитализировнных в год на 10,000 населения во всех типах больниц. Необходимое количество больничных коек, согласно подсчетам, составит 97.06 коек на 10,000 населения, а также 109.44 койки для социальной заботы о населении.

Основная программа ориентирована на интенсификацию использования ресурсов, улучшение структуры медицинских учреждений, как в отношении профиля коек, так и в отношении типа приемов.

Рассчет стоимости основных программ основан на исследовании нужд и расходов медицинского обслуживания за "одну медицинскую услугу" (прием, госпитализацию, т.д.), принимая в учет индексацию.

Вводная информация

(а) Поликлиническое обслуживание

(1) Его расходы (цены декабря 1992) составили 625.14 милиардов рублей

(2) Стоимость одного приема - 469 рублей

(3) Годовые расходы на одного гражданина - 4516.8 рублей (включая 3858.5 рублей на мужчину и 4516.8 рублей на одну женщину)

(б) Больничное обслуживание

(4) Его расходы (цены декабря 1992) составили 727.33 милиардов рублей

(5) Стоимость одной койки в год - 450 тысяч рублей

(6) Стоимость госпитализации одного больного - 19.86 тысяч рублей

(7) Годовые расходы на одного гражданина - 4903.6 рублей (включая 4814.4 рублей на мужчину и 4982.5 рублей на одну женщину)

72.5

Примечание 5: Формула расчетов фондов здравоохранения на душу населения

1. Формула следующая:

$$N_i = \frac{N_{1992}}{\sum_i (t_i * V SMR_i) * \sum_j (P_{ij} * C_j)} * V SMR_i * t_i * \sum_j (P_{ij} * C_j) \qquad (1)$$

где:

N_i - требуемые расходы на здравоохранение в облати i; 15

N_{1992} - местные расходы на здравоохранение в 1992 году в Российской Федерации от уровня 1990 года;

SMR_i - средний уровень смерности в области i;

P_{ij} - население в областной группе j в области i;

C_j - коэффициент затрат в зависимости от возраста на возрастную группу j;

t_i - региональный коэффициент затрат в области i;

Затраты на здравоохранение на 1992 год от уровня 1990 года были рассчитаны применяя возрастную и половую структуру 1992 года и индекс потребительских цен 1992/1990 к расходам на здравоохранение в 1992 году:

$$N_{1992} = N_{1990} / \sum_j [C_j * P_{1990j}] * \sum_j [C_j * P_{1992j}] * INDEX \qquad (2)$$

где:

N_{1990} - реальные местные затраты на здравоохранение в 1990;

INDEX- индекс потребительских цен 1992/1990 .

2. ТРИ ВАРИАНТА ФОРМИРОВАНИЯ МЕСТНОГО БЮДЖЕТА ЗДРАВООХРАНЕНИЯ

Реальные фонды здравоохранения в каждой области формируются следующим образом:

$$H_i = T_i + B_i \qquad (3)$$

где:

H_i - реальные фонды здравоохранения в области i;

T_i - налог на здравоохранения из фондов заработной платы в области i;

B_i - местные бюджетные ассигнования на здравоохранение в области i.

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Налог на здравоохранение от фонда заработной платы в области, Tj рассчитывался по ставке 3,4% от фонда заработной платы. Отклонения отмечены не были.

$$Tj = 0.034 * WBj \quad (4)$$

где:

WB_i - фонд заработной платы в области i.

Предположим, что федеральный бюджет будет субсидировать область, где реальный бюджет на здравоохранения ниже показателя требуемых расходов на здравоохранение.

$$S_i = N_i - H_i, \text{ if } N_i > H_i$$
$$0, \text{ if } N_i <= H_i \quad (5)$$

где:

S_i - федеральные субсидии на здравоохранение области i.

а. Первый вариант ассигнований

Первый вариант ассигнований предполагает, что местный бюджет отчисляет на финансирование здравоохранения не работающих граждан в зависимости от возраста суммы, равные тем, которые получают на основе налога на фонд заработной платы на нужды здравоохранения работающих граждан.

$$B^1_i = T_i * \sum_i [C_i * (P_{ij} - EP_{ij} + CH_{ij})] / \sum_i [C_i * (EP_i - Ch_{ij})] \quad (6)$$

где:

EP_{ij} - работающее население в возрасте j в области i;

CH_{ij} - женщины с детьми до трех лет в области i, применяется только для возраста от 16 до 54 лет, для других возрастов равен 0.

б. Второй вариант ассигнований

Второй вариант финансирования здравоохранения предполагает, что местный бюджет ассигнует на здравоохранение аналогичный процент от валового продукта (GP) области, как и N_{1900} от GP_{1990}:

$$B^2_i = GP_{1992,i} * N_{1990} / GP_{1990} \quad (7)$$

где:

GP_i - экономический потенциал области i.

c. Третий вариант ассигнований

Индекс 1992/90 гг. общих национальных экономических показателей (в реальных ценах) выше, чем индекс потребительских цен 1992/90 гг. (в 23 раза), используемый в качестве индекса цен на медицинские услуги: GDP92~90 = 27, NMP92~90 = 33, GP92~90 = 27. Таким образом,национальная экономика в целом, может обеспечить затраты на здравоохранение на уровне 1990 года. Третий вариант финансирования здравоохранения предполагает, что местный бюджет в дополнение к налогу на фонд заработной платы выделяет на здравоохранение средства в сумме, необходимой для достижения процентного показателя 1990 года от GP:

$$B^3_i = (GP_{1992,i} * N_{1990} / GP_{1990}) - T_i \quad (8)$$

Примечание 6: Данные

1. ДАННЫЕ

a. Население, в целом и по возрастным и половым группам в области в 1992 году и по стране в 1990 и 1992 годах. Следующая возрастная структура применяется в области: "0-15", "16-пенсионный возраст" и, "старше пенсионного возраста". Пенсионный возраст составляет 54 года для женщин и 59 для мужчин. Существуют данные по стране с разбивкой по возрастам и полу (оба пола, каждые 5 лет).

б. Работающие женщины с детьми до трех лет, по области, 1992. Эти данные не доступны. Количество детей до трех лет в области i устанавливалось следующим образом:

$$CH_i = \sum_{j \sim 1990-1992} P_{ij} * NT_{ij} * (1 - IM_{ij}) \quad (9)$$

где:

CH_i - количество детей до трех лет;

P_{ij} - население области i в году j (Госкомстат, 1992a; Госкомстат, 1993a);

NT_{ij} - рождаемость в области i в году j (Госкомстат, 1992a; Госкомстат, 1993a);

IM_{ij} - младенческая смертность в области i в году j (Госкомстат, 1992b; Госкомстат, 1993b);

в. Работающее население, в целом и с разбивкой по возрастным и половым группам по области в 1992. По области доступна информация только по общему количеству работающего населения (Госкомстат, 1993c). Общенациональная возрастная структура была применена для всех областей (Госкомстат, 1993a). Применялась аналогичная возрастная структура ('0-15', '16-пенсионный возраст', и 'старше пенсионного возраста') :

0-15	.28%
16-54(59)	93.35%
55(60)+	6.37%

г. Средний уровень смертности (SMR), по области, 1992. Данные за 1992 год были не доступны. Использовались данные за 1989 год об уровне смертности по возрастным и половым группам ('Медсоцэкономинформ).

$$SMR_i = \sum_j d_{ij} / \sum_j (P_{ij} * \sum_j d_{ij} / \sum_j P_{ij}) \qquad (10)$$

где:

MR_i - Средний уровень смертности в области i;

d_{ij} - смертные случаи по возрастно-половой группе j в области i;

P_{ij} - население в возрастной-половой группе j в области i.

д. Коэффициенты затрат на медицинское обслуживание по возрастным и половым группам. Федеральное Министерство здравоохранения рекомендовало коэффициенты затрат, взвешенных от структурных показателей 1992 года по возрасту и полу населения и укрупненные в соответствии с имеющейся возрастной структурой по областям (Министерство здравоохранения СССР, 1989):

возраст	коэффициент затрат
'0-15'	3.94

729

'16-54(59)'	3.82
'55(60)+'	9.14

е. Коэффициент цен на медицинское обслуживание по области, 1992. Информация не доступна. Использовалась информация о стоимости основных продуктов питания по экономическим регионам (Федеральный центр экономического анализа и прогнозирования, 1993).

ж. Местные затраты на здравоохранение, 1990, 1992. Эта информация доступна (рабочие таблицы Федерального Министерства здравоохранения).

N_{1990} = 13,112.9 млн. рублей.

з. Индекс цен на медицинские услуги 1992/90 гг. Индекс не доступен, применялся индекс потребительских цен 1992/90 гг. (Госкомстат, 1992а; Госкомстат, 1993а):

INDEX = 22.99 раз

и. Фонд заработной платы по областям, 1992. Информация по фондам заработной платы не доступна. Они были оценены следующим образом:

$$WB_i = 12 * (EP_i - CH_i) * W_i \qquad (11)$$

где:

WB_i - фонд заработной платы в области i;

EP_i - работающее население в области i (Госкомстат, 1993с);

W_i - средняя заработная плата в области i (Госкомстат, 1993b).

Предположили, что другие категории работающих (фермеры, частные предприниматели, и т. д.) получали аналогичную среднюю заработную плату. Женщины с маленькими детьми не получают заработную плату, хотя и включены в штатные списки.

к. GDP или NMP, по области, 1992; национальные, 1990. Данные на уровне области не доступны. Оценка валового продукта области (GP) была получена за 1990 и 1992 годы следующим образом:

$$GP_i = IP_i + AP_i + PS_i \qquad (12)$$

где:

IP_i - валовый промышленный продукт в области i (Госкомстат, 1993c);

AP_i - валовый сельскохозяйственный продукт области i (рабочие таблицы Госкомстата);

PS_i - объем платных услуг в области i (Госкомстат, 1993a).

Данные по АР на областном уровне за 1992 год доступны только в ценах 1983 года. Они были исправлены в соответствии с реальными государственными ценами АР. (Госкомстат, 1993a).

л. Среднегодовой курс обмена за 1992 год. Он был установлен как средний показатель по данным по данным на начало и конец каждого месяца 1992 года (Федеральный Центр экономического анализа и прогнозирования, 1993).

Курс обмена $_{1992}$ = 209.4 рублей за 1 USD

2. ИСТОЧНИКИ ИНФОРМАЦИИ

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Научно-производственное объединение по вопросам медицинской, социальной и экономической информации при Министерстве здравоохранения Российской Федерации ('Медсоцэкономинформ'). Рабочие таблицы по данным об уровне смертности по возрастным и половым группам за 1989 год.

HEALTH CARE FINANCING

PRESENTATION CHARTS

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Objectives of the health care financing project

Methodology

Diagnosis of the current situation

Main evolutionary scenarios

Key issues and areas for improvement

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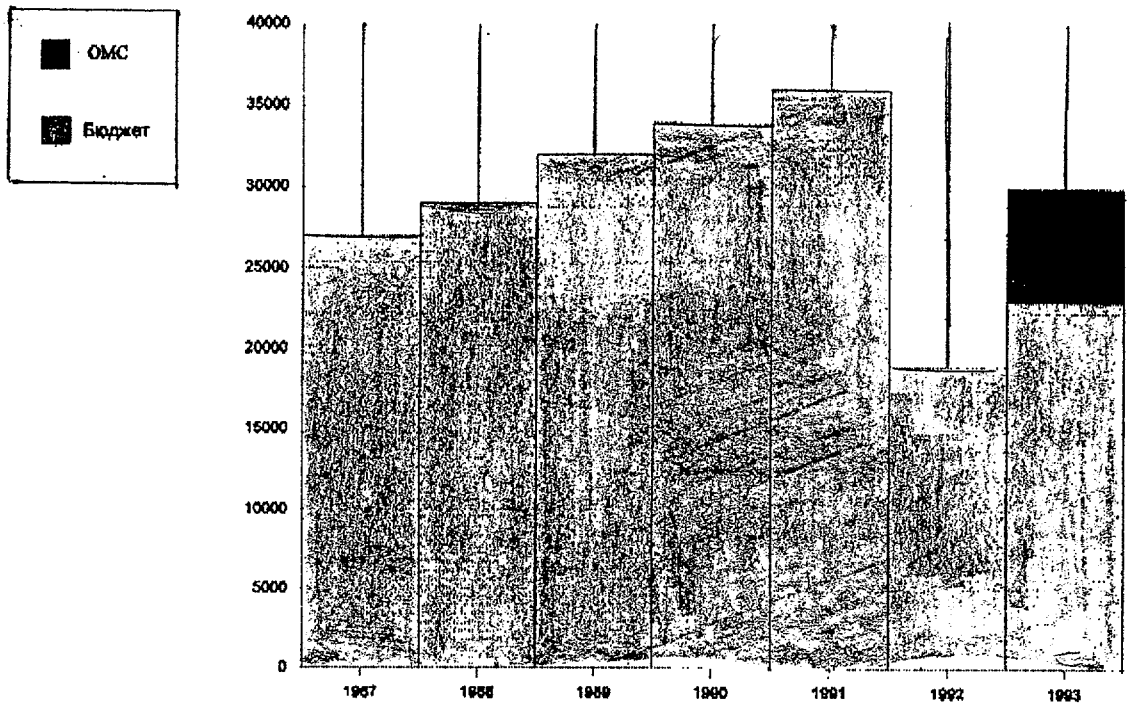
ТЕРРИТОРИЯ	Первый Вариант	Второй Вариант	Третий Вариант
Ярославская обл.	3.7	16.0	8.7
ВОЛГО-ВЯТСКИЙ РАЙОН			
Республика Мари-Эл	0.1	0.7	-1.8
Республика Мордовия	1.0	3.5	0.0
Республика Чувашия	1.9	4.3	-0.7
Кировская обл.	5.2	7.8	0.1
Нижегородская обл.	11.5	33.3	15.8
ЦЕНТРАЛЬНО-ЧЕРНОЗЕМНЫЙ РАЙОН			
Белгородская обл.	7.8	15.2	7.9
Воронежская обл.	3.6	7.8	-1.0
Курская обл.	3.9	8.8	3.0
Липецкая обл.	4.6	15.6	9.9
Тамбовская обл.	1.9	3.6	-1.3
ПОВОЛЖСКИЙ РАЙОН			
Республика Калмыкия	0.0	0.2	-0.8
Республика Татария	15.8	37.6	20.4
Астраханская обл.	2.0	1.0	-2.8
Волгоградская обл.	10.9	21.7	9.8
Пензенская обл.	1.4	4.5	-0.8
Самарская обл.	22.2	52.9	33.7
Саратовская обл.	6.2	13.9	3.1
Ульяновская обл.	5.6	10.9	4.4
СЕВЕРНЫЙ КАВКАЗ			
Республика Адыгея	-0.1	-0.9	-2.1
Республика Дагестан	-2.9	-6.0	-8.7
Республика Кабардино-Балкария	-1.0	-1.3	-3.2
Карачаево-Черкесская республика	-0.7	-0.3	-1.3

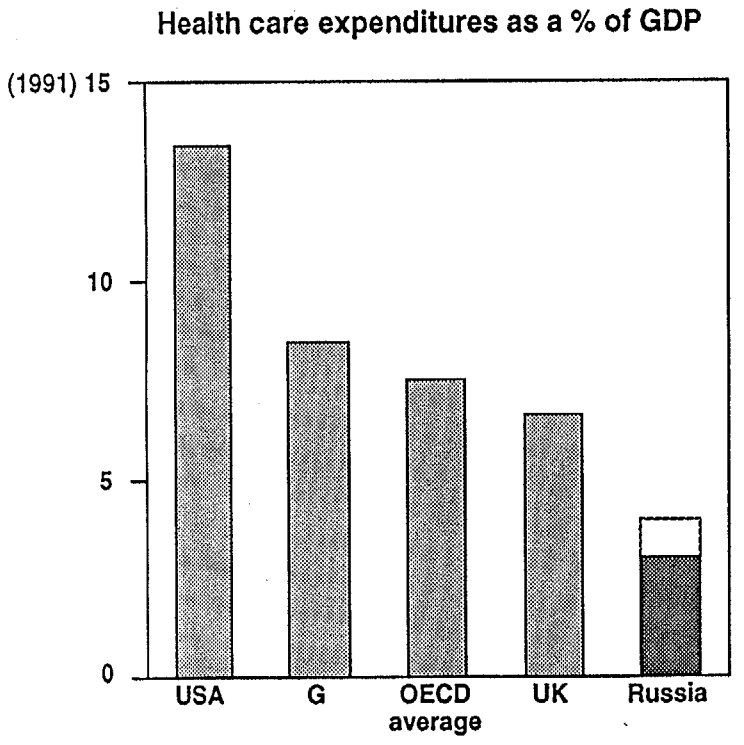
ТЕРРИТОРИЯ	Первый Вариант	Второй Вариант	Третий Вариант
Республика Северная Осетия	-0.7	-0.6	-2.2
Чечено-Ингушская республика	-2.9	-3.6	-5.5
Краснодарский край	5.4	0.8	-16.6
Ставропольский край	0.5	0.5	-7.8
Ростовская обл.	3.5	11.2	-7.3
УРАЛ			
Республика Башкирия	17.0	44.6	24.2
Республика Удмуртия	3.2	8.4	0.5
Курганская обл.	1.4	2.5	-2.2
Оренбургская обл.	11.0	18.5	6.7
Пермская обл.	14.2	28.8	11.1
Свердловская обл.	32.5	58.6	27.8
Челябинская обл.	22.0	40.0	18.8
ЗАПАДНО-СИБИРСКИЙ РЕГИОН			
Горный Алтай	-0.4	-0.9	-1.5
Алтайский край	0.0	3.8	-8.0
Кемеровская обл.	39.9	43.3	14.5
Новосибирская обл.	3.8	3.1	-9.5
Омская обл.	5.4	15.9	5.4
Томская обл.	5.7	7.2	0.8
Тюменская обл.	75.5	127.4	80.3
ВОСТОЧНО-СИБИРСКИЙ РЕГИОН			
Республика Бурятия	4.7	1.1	-4.2
Республика Тува	-0.8	-1.7	-2.5
Республика Хакассия	3.4	5.4	2.0
Красноярский край	34.2	54.1	26.7
Иркутская обл.	25.6	33.2	13.0

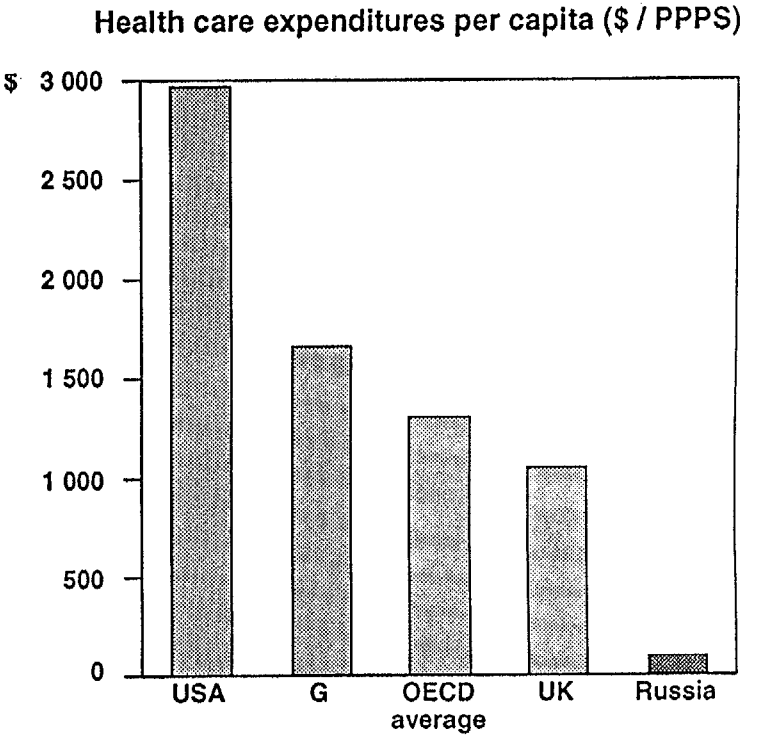
ТЕРРИТОРИЯ	Первый Вариант	Второй Вариант	Третий Вариант
Читинская обл.	6.4	-0.3	-6.8
ДАЛЬНЕВОСТОЧНЫЙ РЕГИОН			
Республика Якутия-Саха	17.8	20.6	5.4
Приморский край	4.1	-1.1	-15.0
Хабаровский край	8.4	3.7	-9.1
Амурская обл.	3.1	-0.4	-7.1
Камчатская обл.	3.7	1.5	-2.7
Магаданская обл.	9.4	11.4	2.3
Сахалинская обл.	4.7	3.6	-2.7
Калининградская обл.	0.4	1.3	-2.3
ФЕДЕРАЛЬНЫЕ СУБСИДИИ	10.9	17.7	239.5
федеральная доля в налоге на фонд заработной платы (0,2%) в % к федеральным субсидиям	428%	263%	19%

График 1
Реальные государственные расходы на здравоохранения снизились на 95% в 1992
(млн рубл. 1991 г.)



HEALTH CARE EXPENDITURES IN RUSSIA ARE SIGNIFICANTLY BELOW OECD COUNTRIES





Informal expenditures (unaccounted officially)

Source : OECD, World Bank, unpublished data from Ministry of Health, Goskomstat, BCG estimate

THE CURRENT HEALTH CARE REFORM CREATES MAJOR CHANGES IN MANAGEMENT AND FINANCING OF HEALTH CARE (I)

Introduction of a Compulsory Medical Insurance system (CMI) coexisting with local budget financing system

Sources of funds

- Employers are required to pay a 3.6% payroll tax to cover employees
- Contributions from local budgets cover unemployed population and special programs
- CMI funds are responsible for collecting the major part of funds from both employers and local authorities

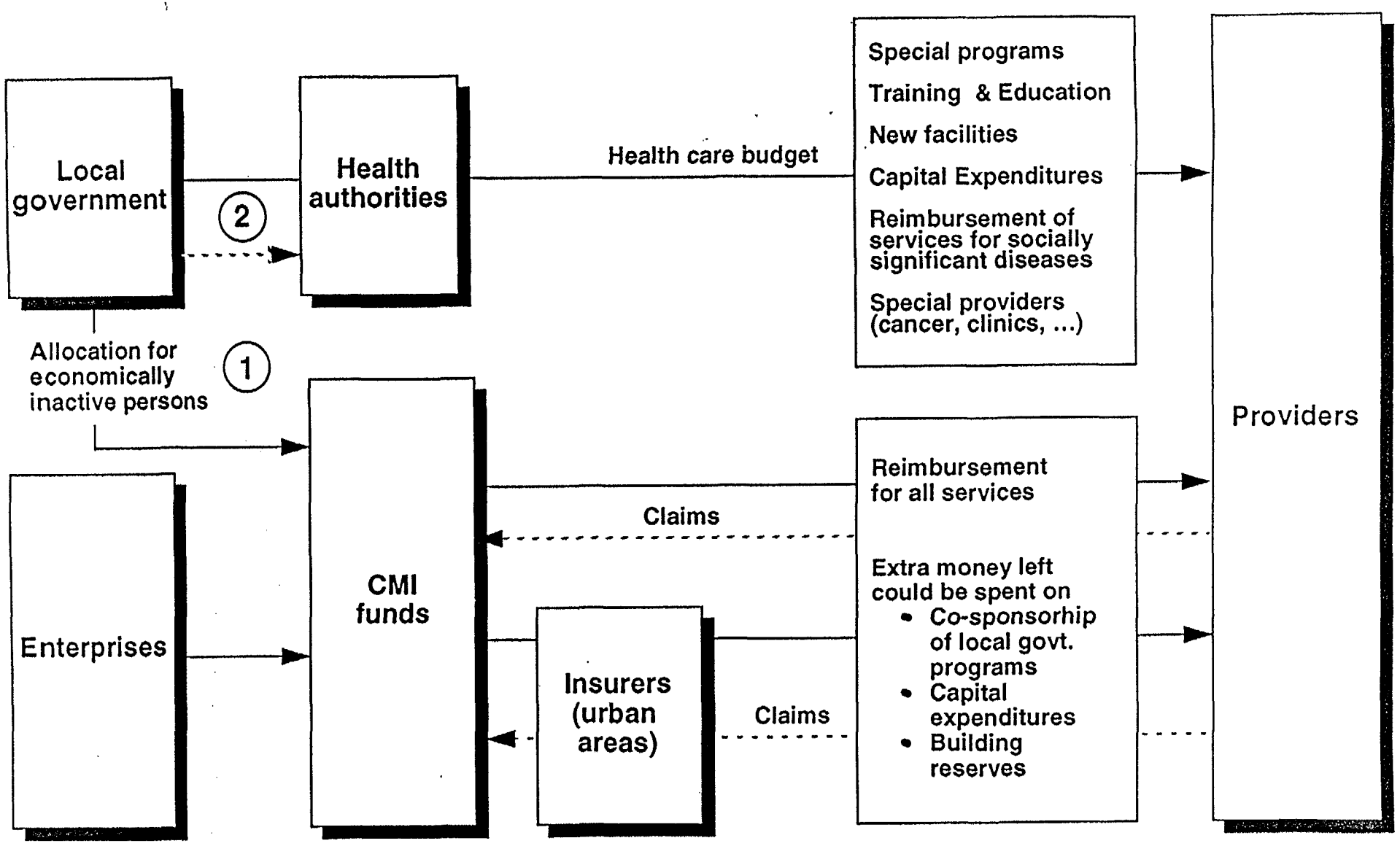
Uses of funds

- Providers are reimbursed on the basis of operations performed, cases treated (DRG) or capitation
- Funds are distributed to providers via insurance companies or directly by the CMI funds
  - in some cases funds can be distributed directly by the local health authorities

Providers management

- Insurance companies (or CMI funds if there are no insurance companies) must play an active role in monitoring costs and quality of health care delivery

THE CURRENT HEALTH CARE REFORM CREATES MAJOR CHANGES IN MANAGEMENT AND FINANCING OF HEALTH CARE (II



KEY OBJECTIVES OF THE HEALTH CARE FINANCING PROJECT

To understand current financial flows, from all sources to health care providers

To identify and explain regional variations

To assess the viability of the new system under overall tight financing constraints

To identify main sources of inefficiencies and areas for improvement

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METHODOLOGY (I)

Macro perspective

National level
- Major sources of funds
- Major uses of funds (providers)
- Evolution over time

Main information sources
- Federal Funds
- Goskomstat
- World Bank
- Economist Intelligence Unit

Micro perspective

Regional level (sample of regions)
- Detailed sources of funds
- Detailed uses of funds
- State of implementation of health care reform

Main information sources
- Local Health Department
- CMI fund
- Insurance companies
- Providers (Hospital, Polyclinics)

Financing model

Simulations/ Sensitivity to key parameters

METHODOLOGY (II)
Region selection

Sample to be representative of diversity along 2 main dimensions

- Wealth of the region (ie its ability to fund health care expenditures)
  - local public funds (budget financing)
  - employers' contribution potential (average monthly wages used as a proxy)
- State of implementation of the reform / efficiency of the key players

⇩

7 regions selected

- Arkhangelsk
- Tver
- City of Moscow
- Novgorod
- Barnaul
- Novosibirsk
- Krasnoyarsk

⇨ Chosen regions have total population of 21.1 million (14% of Russia)

METHODOLOGY (III)
Field research

In each region, interviews with the key players

- Local Health Care authorities
- Regional Compulsory Medical Insurance (1) Fund
- Insurers (Compulsory Medical Insurance (1) + Voluntary Medical Insurance)(2)
- Large providers (Hospitals, Polyclinics)

Focus on

- Actual structure of the financing system (and likely evolution)
- Operational efficiency (benchmarking of the different players)
- Main problems faced during implementation of the reform

(1) CMI
(2) VMI

METHODOLOGY (IV)
List of interviews

Region	Company	Contact	Position	Date
Moscow	Moscow Health Care Authority	Ms Panina Lyudmila Pavlovna	Dept. Head, Finance & Planning	23 June
	Moscow City Fund of Compulsory Insurance	Mr Lomakin-Rumyantsev	Executive Director	16 March
	Medstrakh Insurance Company (CMI+VMI)	Mr NP Chelidze	Deputy Dir of Health Insurance	14 July
	Asko (VMI+other)	Ms NA Mints Ms IV Loukyanova	Chief of Medical Care Insurance Chief of Life & Health Insurance	8 July
	Naiko (VMI+other)	G Smirnov B Evgenii	Vice President Dir of Medical Care Insurance	8 July
	City Hospital 79	Mr IE Alexandrovich	Head Doctor	13 July
	City Hospital 31	Mr Goluhin	Chief Doctor	22 June
	Polyclinic 58	Mr IG Suslov	Head Physician	13 June
Novgorod	Novgorod City Administration	L Semenova	Head of Financial Dept, City Budget	29 June
	CMI Fund	LV Timofeeva	Executive Director	29 June
	CMU Fund & Health Administration	VA Medik	Chairman CMI Fund, Head Health Administration	30 June
	Oblast Administration	LS Agafonova	Head of Oblast Budget	29 June
	Asko (VHI)	IS Gremitskih	General Director	30 June
	Polyclinic 1	VA Zvetkova	Chief Doctor	30 June
	Veterans Hospital		Head	30 June

METHODOLOGY (V)
List of interviews

Region	Company	Contact	Position	Date
Altai Krai/Barnaul	Siberian Association of Public Health & Local Health Administration	Mr NF Gerasimenko	Head & President	11&12 July
	Regional CMI Fund	OV Andreeva	Deputy Director	12 July
	Commission for Quality Control	IA Egorova	Head of Department	11 July
	Private Insurer	VV Kuznezov	Director	12 July
	Altai Diagnostic Centre	V Cheganov	Chief Doctor	12 July
	Central (Hospital)	EP Osipov	Head of Hospital Chief Doctor	11 July
Tver	Oblast Administration, Territorial CMI Fund, Oblast Administration	AV Kozazev BI Mogilevsky IA Mishanova	Head of Health Care, Deputy Head, Chief Economist	27 June
	Regional Administration	Z I Gubanova	Assistant Chief Financial Office, Head of Budget Department	28 June
	Tver CMI Fund	Ziobin Alexander Nikolaevitch	Executive Director	28 June
	Tarzhok Central Hospital with 2 Polyclinics	AV.Mikhailovich	Chief Doctor	28 June

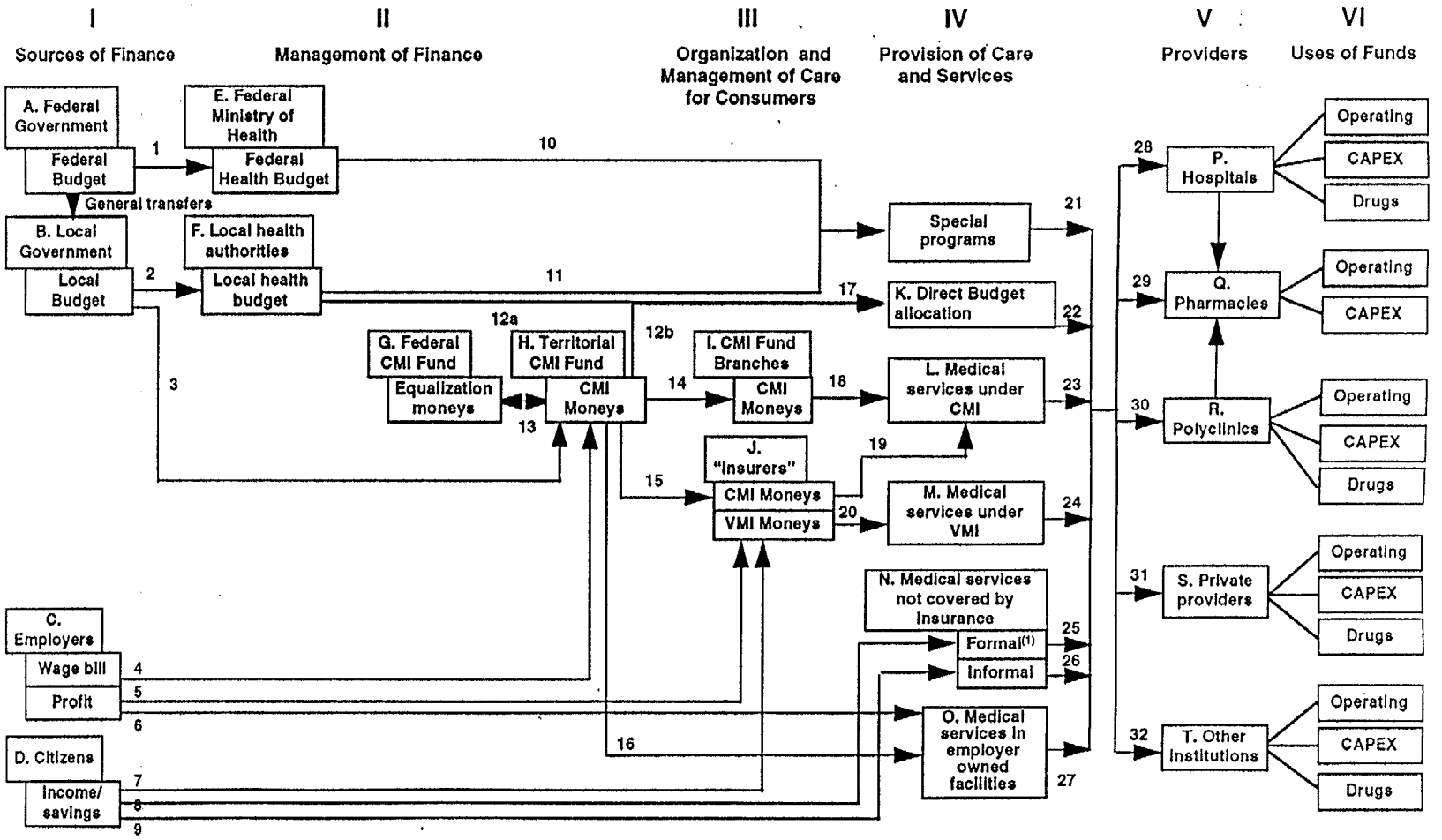
METHODOLOGY (VI)
List of interviews

Region	Company	Contact	Position	Date
Novosibirsk	CMI Fund	A Reshetnikov	Director General	6 July
	Azopo Zhizn (CMI)	IA Ivaninskaya	Director General	6 July
	Enterprise Owned Hospital & Polyclinics	L Kanunnikova	Head Physician	5 July
	CIM Central Hospital I	Leonid Fedorovich	Chief Doctor	5 July
Krasnoyarsk	Regional CMI Fund	SM Goryachev	Director	13 July
	Local Health Administration	BP Mashtakov	Directorate Chief	13 July
	Medika Insurance Company	GK Fzolova	General Director	13 July
	Divnogorsk City Clinic (Hospital)	L Egorov	Chief Doctor	14 July

METHODOLOGY (VII)
List of interviews

Region	Company	Contact	Position	Date
Archangelsk	Local Administration	S.D. Emmanulov / N.M. Filipovna	Director	21 July
	CMI Fund	GE Ezmolkina	Director	21 July
	Administration of Archangelsk Oblast	EM Gordon	Deputy Head, Oblast Financial Department	22 July
	Maks Insurance company	VV Trofimov	Director	22 July
	Novodvinsk hospital	NS Danilin	Chief Doctor	22 July
National / Other	Federal CMI Fund	Mr V Yu Semenov	Deputy Chairman	29 June
	Samashko Research Institute for Social Hygiene, Health Economics & Management	Mr A Lindenbraten	Head of Public Health Economics Division	12 July

RUSSIAN HEALTHCARE FINANCING MODEL



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LIMITS OF THE ANALYSIS

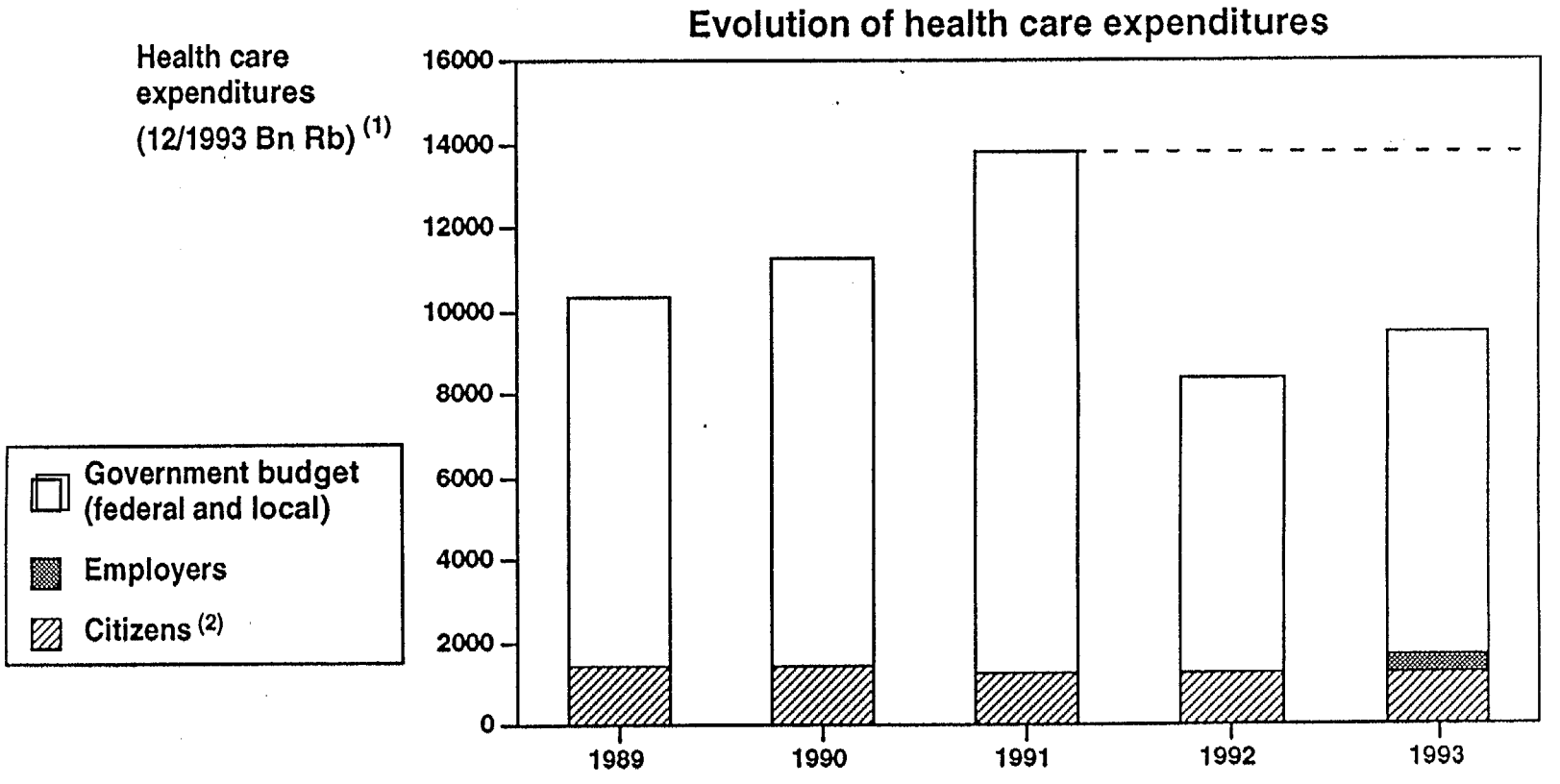
For flows which were taken into account

- Lack of reliable national data
- Sample size (7 regions)
- Availability of data in the regions
- Sensitivity of inflation adjustments for nominal expenditure

Flows which were not taken into account at this stage

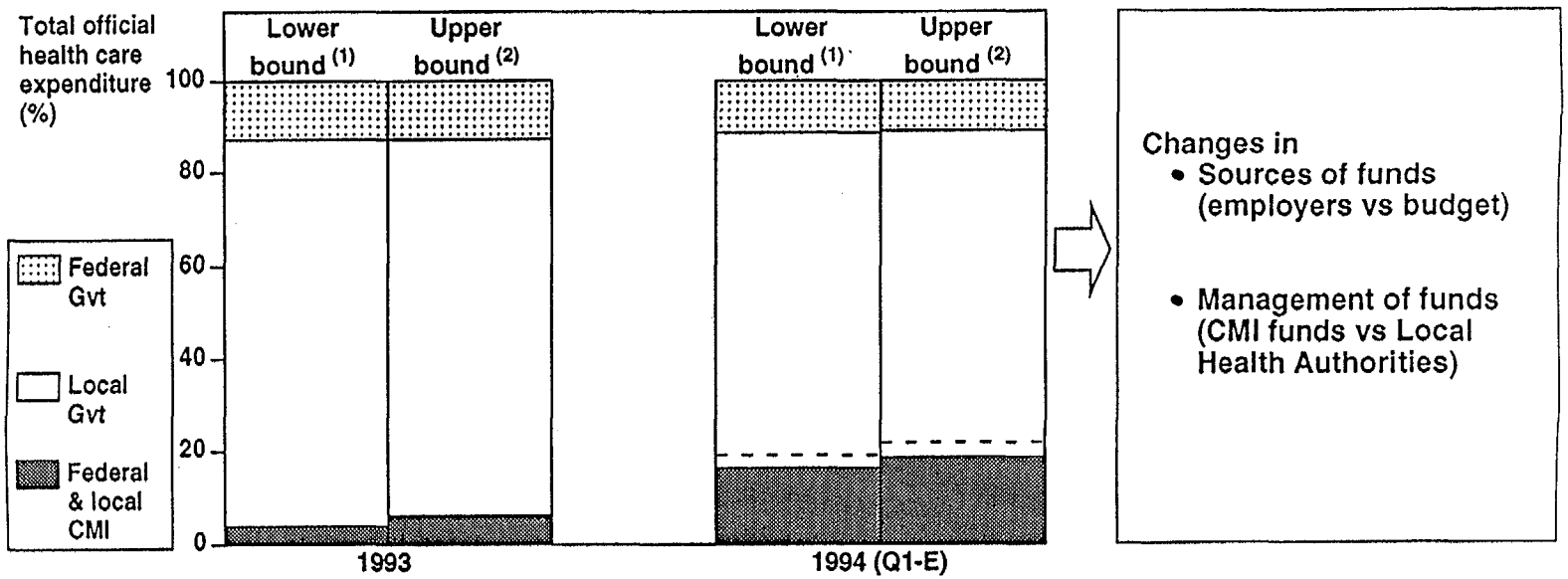
- Unofficial flows
- Health care networks directly managed by national administrations
- Private providers

THE DEVELOPMENT OF CMI FINANCING HAS NOT BEEN SUFFICIENT YET TO BRIDGE THE GAP WITH THE 1991 LEVEL OI HEALTH CARE EXPENDITURES



(1) Inflation adjusted to Dec 1993 Rb using monthly CPI 1991-1993; annual CPI index for 1989 & 1990
(2) Assume stable contribution over 1991-1993
Source: World Bank report (health sector reform in Russia 12/93), Federal CMI fund estimate, BCG analysis

LOCAL BUDGET IS STILL THE LARGEST SOURCE OF FUNDS BUT THE FINANCING STRUCTURE IS CHANGING (I)



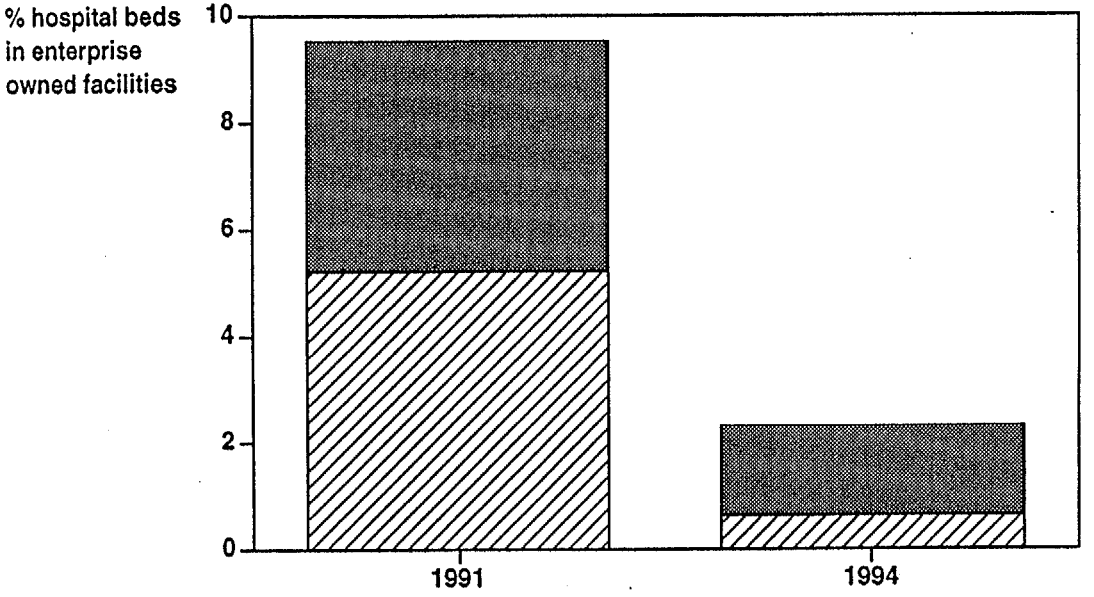
CMI scope for funds management

Note: 1. CMI fund expenditures through insurers, CMI Branches, and in agreement with LHA
2. Total CMI funds expenditures

Source: World Bank, Goskomstat, Federal CMI Fund, BCG analysis

ENTERPRISE FUNDED HOSPITAL BEDS DECREASED FROM 10% TO 2.3% OF TOTAL 1991 TO 1994

Total national health care funding from enterprises decreased from 5% to 1%



Key drivers of this change include

- Current economic conditions
- Reduction in social expenditures
- Downsizing of enterprise activities
- Requirement to contribute 3.6% wagebill to CMI Fund

Local Gov't/CMI funding

Enterprise funding

Source: BCG Enterprise Poll of around 40 enterprises in 5 regions conducted by telephone interview from 2-9 August 1994

IN ADDITION TO OFFICIAL FUNDING, INFORMAL SOURCES OF FUNDS COULD REPRESENT A SIGNIFICANT ALTERNATIVE SOURCE OF FUNDS

Volumes and transparency of informal flows appear to vary significantly

- Only indirect estimates available (from +20% to +40% of total health care expenditures?)

Moscow city providers seem to receive a relatively large portion of financing unofficially

- A small proportion of which has been used to purchase equipment

Informal flows seem less common in the regions outside Moscow

- None of interviewees admitted significant "black market" flows

Informal flows create distortions in health care provision

- Scarce resources are reallocated to "cash patients" which amplifies underfunding for majority of population
- Informal flows do not get reinvested in health care

Source : BCG Interviews

THERE ARE MAJOR DIFFERENCES BETWEEN REGIONS

Main factors

State of implementation of the reform

- Population coverage

Roles and missions of the various players

Funding structure

- Funds channelled through CMI funds or directly to the providers
- Existence of insurance companies
- Providers coverage

Wealth of the region

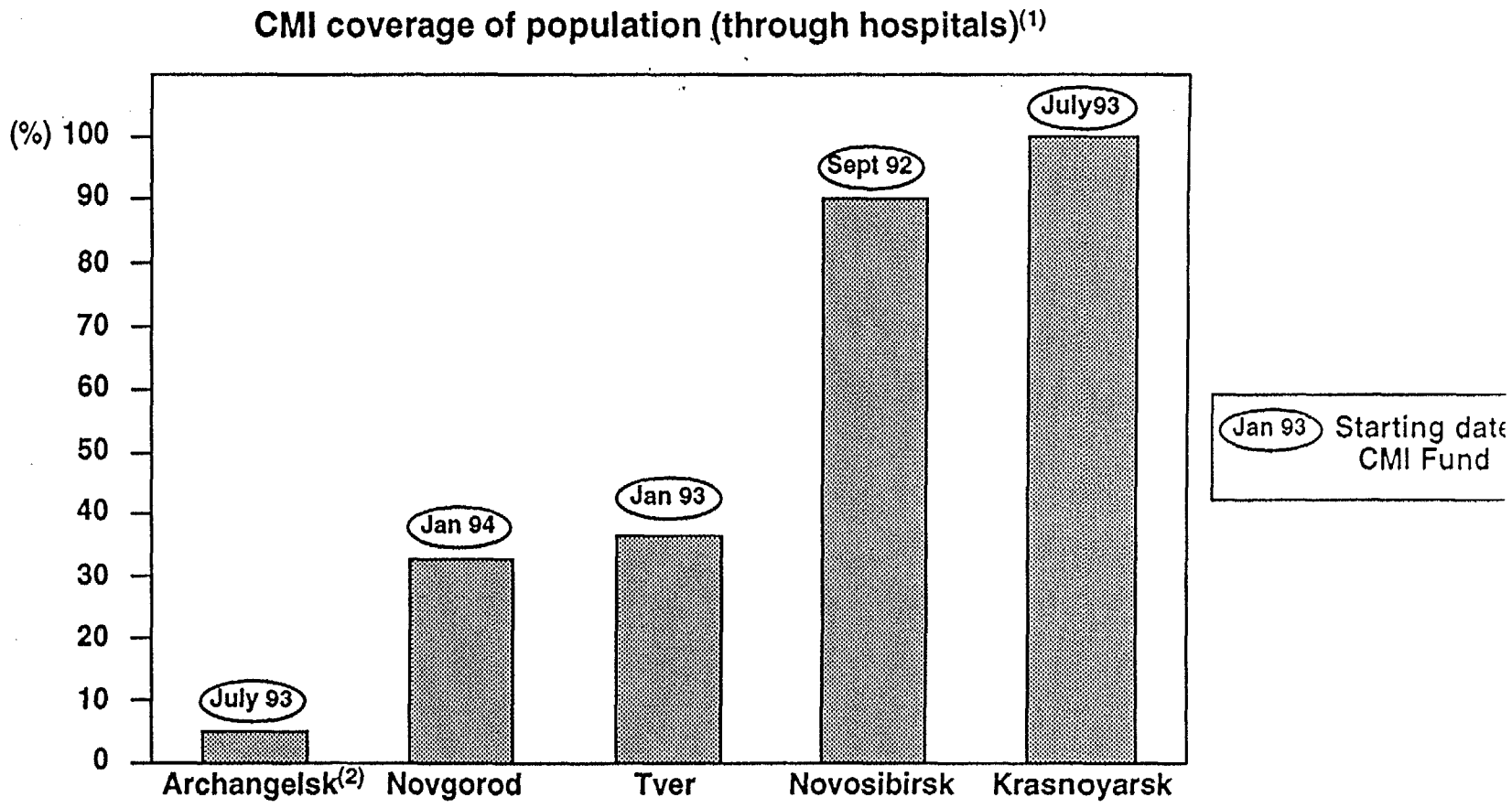
- Enterprise contribution potential
- Local budget contribution

Operational efficiency of the financing system

- CMI tax collection yield
- Level of commissions

Efficiency of the health care delivery system

DIFFERENCES IN STATE OF IMPLEMENTATION OF THE REFORM



(1) Population coverage of hospitals funded directly by CMI Funds. This does not include CMI Funds directed by local Health Authorities.
(2) CMI Fund temporarily allocates 62% of their funds to two oblast level institutions at the request of local health administration.
Source : BCG regional interviews and analysis

DIFFERENCES IN MISSIONS / ROLES OF KEY PLAYERS

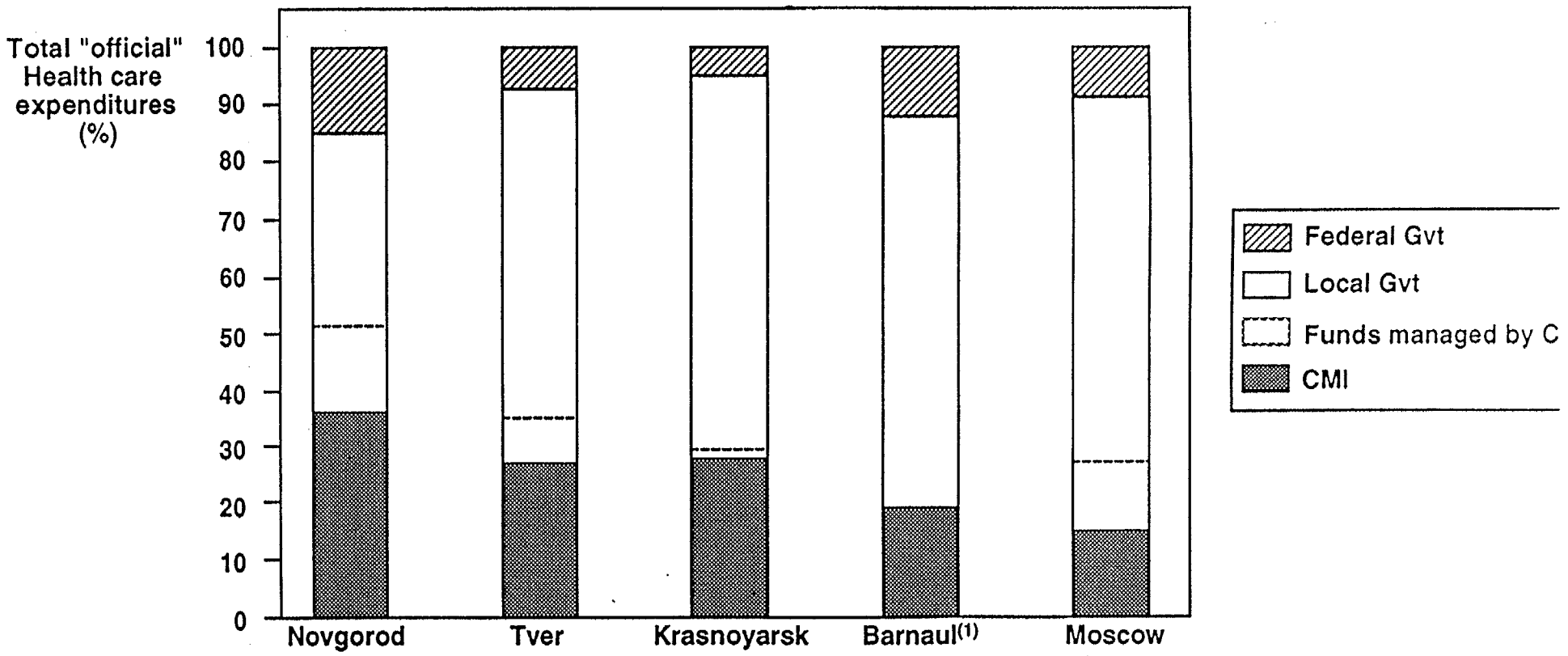
	Archangelsk			Novgorod			Tver			Novosibirsk			Krasnoyarsk			Barnaul			Moscow		
	CMI	LHA	INS	CMI	LHA	INS	CMI	LHA	INS	CMI	LHA	INS	CMI	LHA	INS	CMI	LHA	INS	CMI	LHA	INS
Quality control		X			X		X	X			X	X	X	X			X		X	X	X
Cost control		X	X	X	X		X	X			X	X	X	X	X	X	X	X	X		X
Distribution of CMI funds	X		X	X			X		X			X	X			X					X
Financing of medical services	X	X	X	X	X		X	X	X		X	X	X	X	X		X			X	X
Financing of investments		X			X		X	X			X			X			X		X		X
Collection of enterprises funds	X			X			X			(1)			(1)			X			X		

CMI : Compulsory Medical Insurance
LHA : Local Health Authorities
INS : Insurers
Source : BCG regional interviews and analysis

X = Minor flow
(1) Tax authorities responsible for collection

DIFFERENCES IN FUNDING STRUCTURE (I)

CMI vs direct financing of providers by local government (1994 Q1 + Q2)



(1) Barnaul CMI fund does not receive funds from budget for economically inactive persons
Source : BCG regional interviews and analysis

DIFFERENCES IN FUNDING STRUCTURE (II)
CMI insurance companies

	Archangelsk	Novgorod	Tver	Novosibirsk	Krasnoyarsk	Barnaul	Moscow
# of insurers with CMI license	1	1	1	8	5	2	20
% CMI expenditure(1) via insurers	70%	0%	1%	100%	27%	0%	100%
Type of competition	Monopoly	-	-	• Monopoly for inactive population • Competition for workers	Monopoly	-	High competition

(1) Does not include CMI funds directed by Local Health Authorities

Source : BCG regional interviews and analysis

DIFFERENCES IN FUNDING STRUCTURE (III)
Provider coverage

Most regions channel CMI moneys exclusively to urban hospitals to reduce burden on budget and to expand CMI coverage rapidly

Polyclinics should receive CMI moneys after all hospitals are covered

Most CMI Funds interviewed indicated a limited number of polyclinics would be covered by early 1995

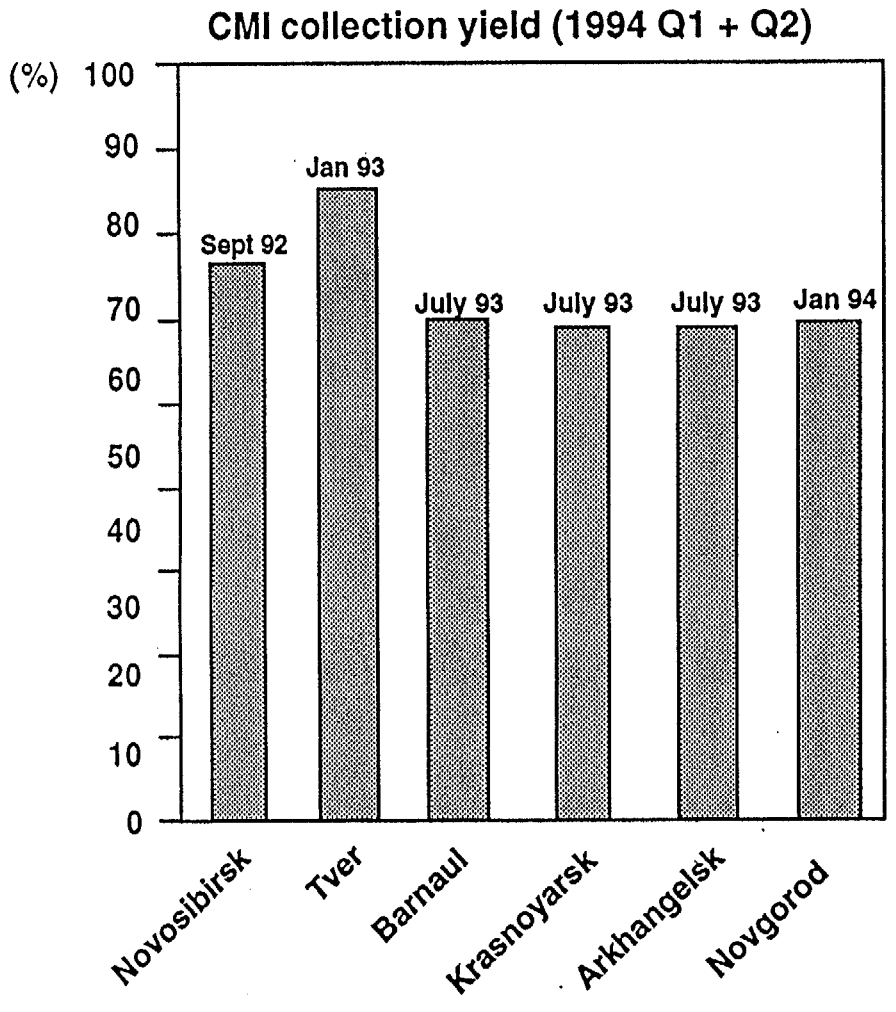
Notable exceptions

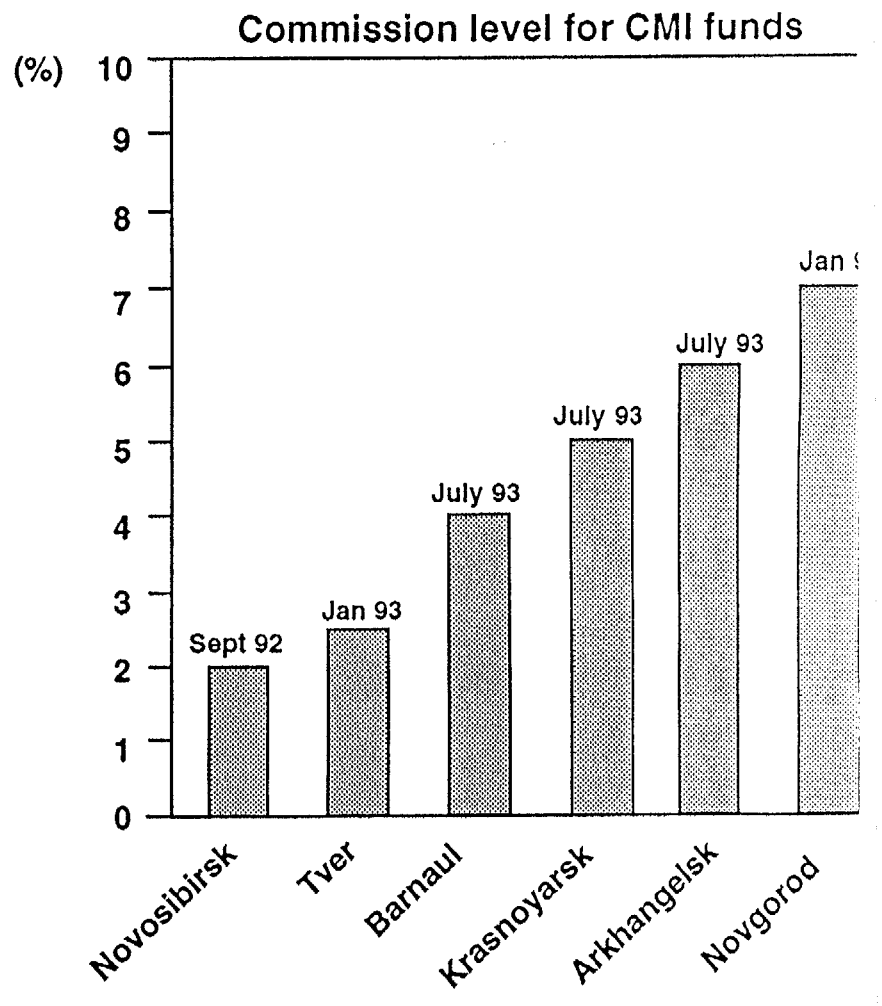
- Tver began with poorly funded rural hospitals because urban hospitals were unwilling to risk losing funds from budget
- Novgorod and Barnaul, despite a shortage of funds, started hospitals and polyclinics simultaneously
- Moscow began with polyclinics, and currently CMI funds provide almost 50% of polyclinic expenses

Source : BCG regional interviews and analysis

DIFFERENCES IN OPERATIONAL EFFICIENCY (I)

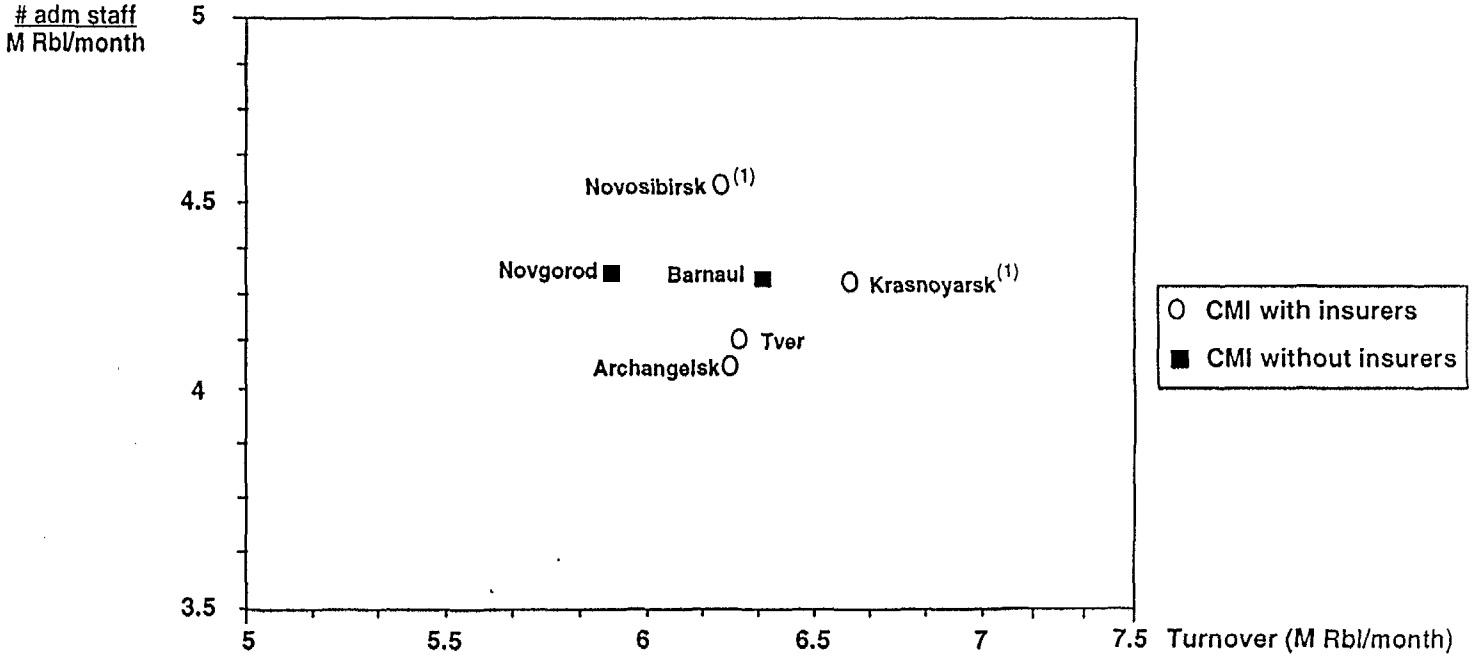
Collection yield and commission levels





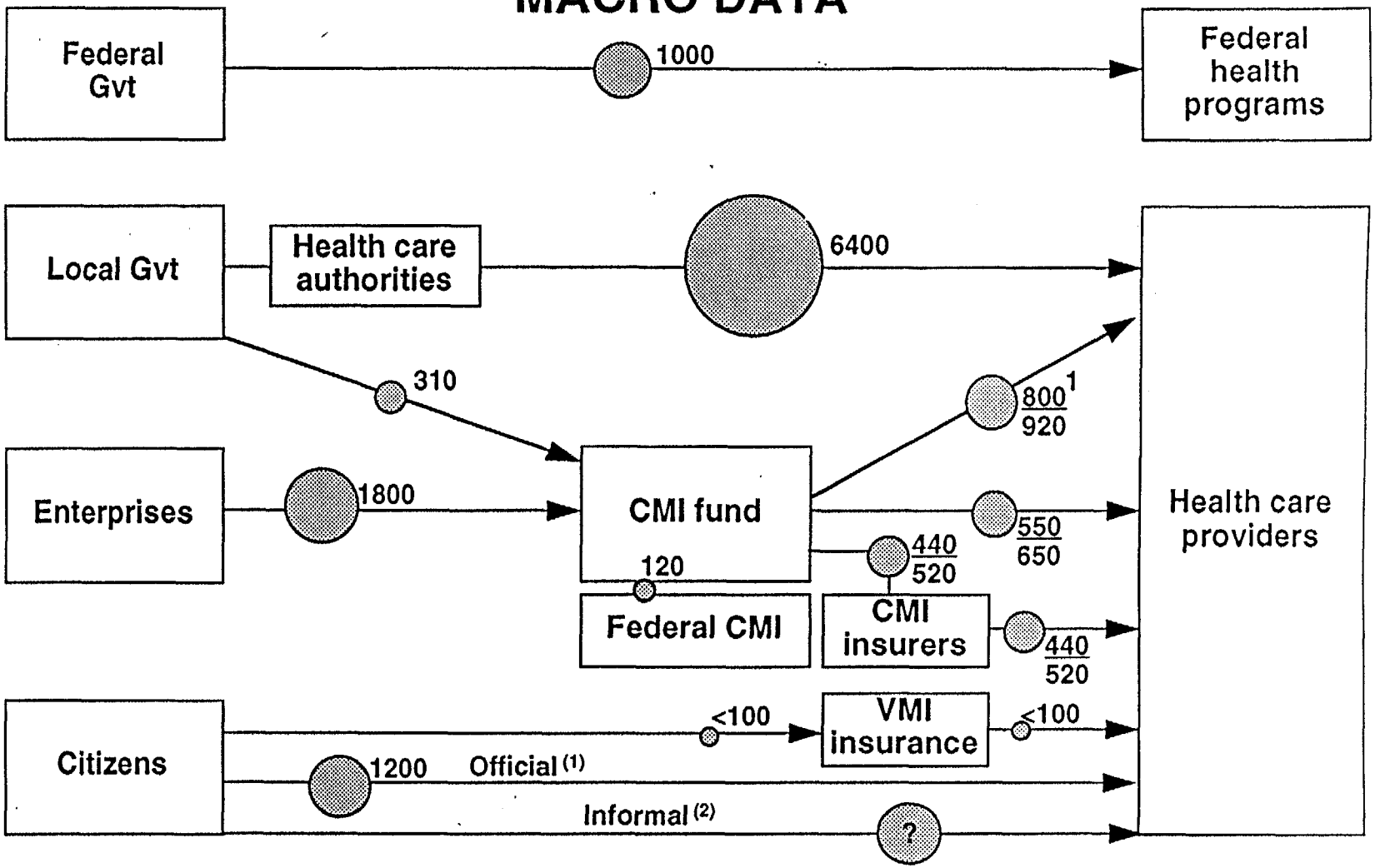
Source : BCG regional interviews and analysis

DIFFERENCES IN OPERATIONAL EFFICIENCY (II)
Operational efficiency of CMI funds



(1)External collection
Source : BCG regional interviews and analysis

NATIONAL FLOW ESTIMATES (FIRST QUARTER 1994)
MACRO DATA



Note: Flows annualised from first quarter data; 12/1993 billion roubles

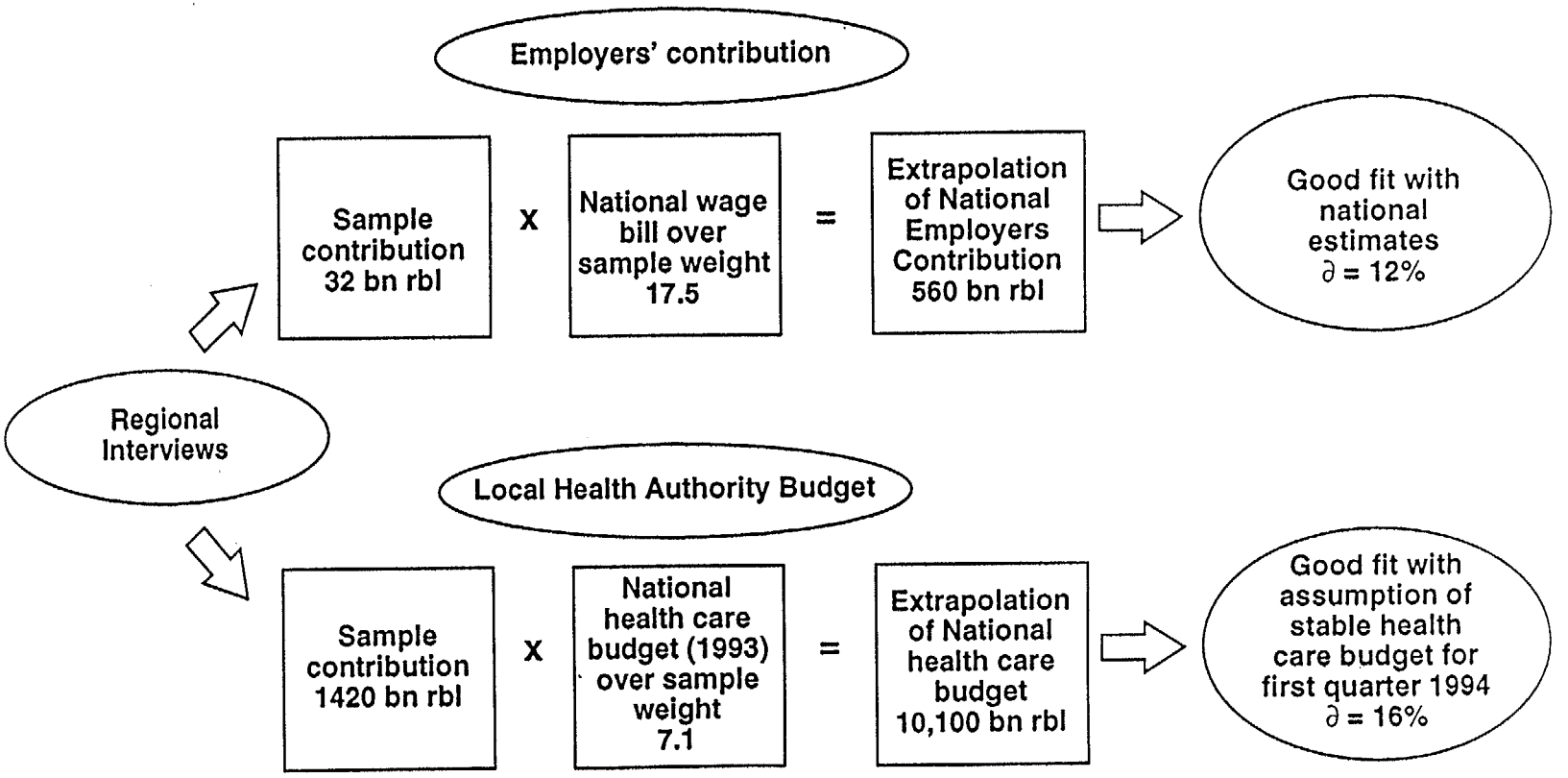
1 $\frac{a}{b}$ refers to the level of actual flow (a) relative to the projected flow (b)

$\frac{a}{b}$ 1000 Rbl bn (12/93)

Sources: Federal CMI Fund, World Bank, Goskomstat

NATIONAL FLOW ESTIMATES (FIRST QUARTER 1994) EXTRAPOLATION

Regional extrapolation confirms national estimates



Note: Roubles inflation adjusted using monthly CPI index; 12/1993 roubles

Source: BCG regional interviews & analysis

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Main evolutionary scenarios

Key issues and areas for improvement

HOW VIABLE OR SUSTAINABLE IS THE NEW FINANCING SYSTEM ?

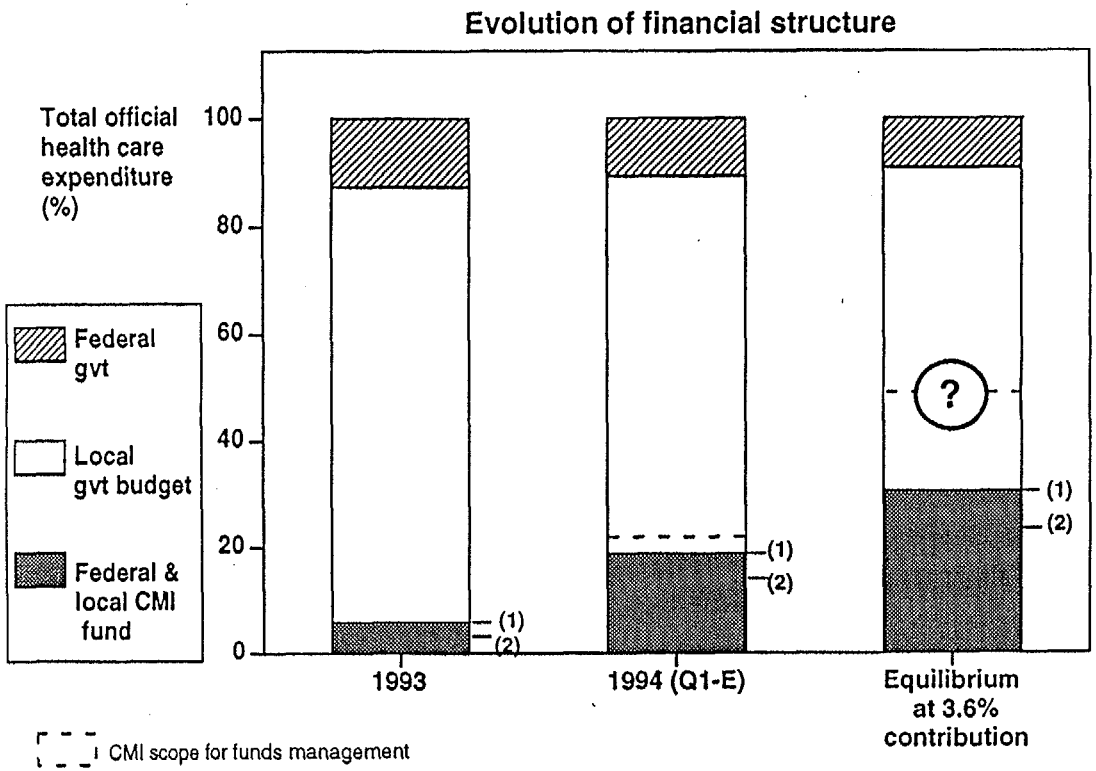
What will be the funding structure when CMI funds are fully operational ?

How viable is the health care system with the new funding situation ?

- Is local government amount sufficient ?
- Is enterprise amount sufficient ?

How could unemployment impact the funding situation ?

SIMULATED EQUILIBRIUM INDICATES THE MAJORITY OF FINANCING WILL STILL COME FROM LOCAL GOVERNMENT



Equilibrium assumptions

- 3.6% CMI rate
- 95% collection rate for CMI funds
- Constant real Federal and Local government contribution
- Average wage in March 1994

CMI scope for funds management

Note: Inflation adjustment based on monthly CPI

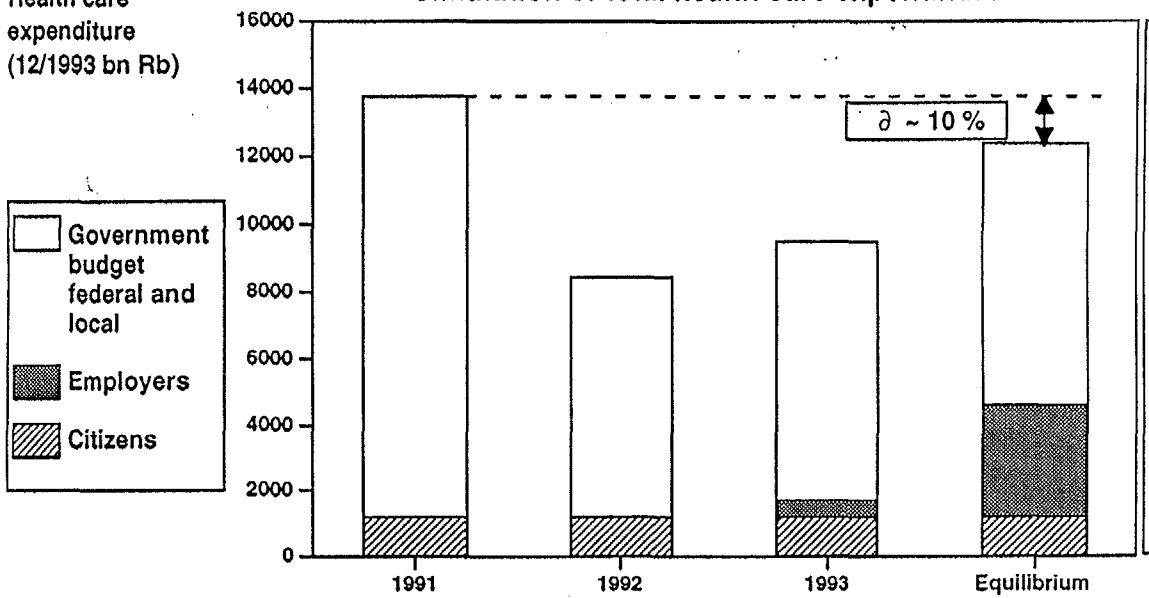
(1) Upper bound includes all CMI expenditures

(2) Lower bound includes all CMI expenditures through insurers, branches & in agreement with LHA

Source: Goskomstat, BCG regional interviews and analysis

EVEN AT EQUILIBRIUM THE FUNDING STRUCTURE IS UNLIKELY TO BRIDGE THE GAP WITH 1991 EXPENDITURES

Simulation of total health care expenditures



Key assumptions

- 3.6% CMI rate
- 95% collection rate for CMI funds[1]
- Constant real Federal and Local government contribution
- Average wage in March 1994

To reach 1991 levels
- **Local governments would need to increase the health budget by ~20%**

Or
- **Employers should contribute ~5% of payrolls**

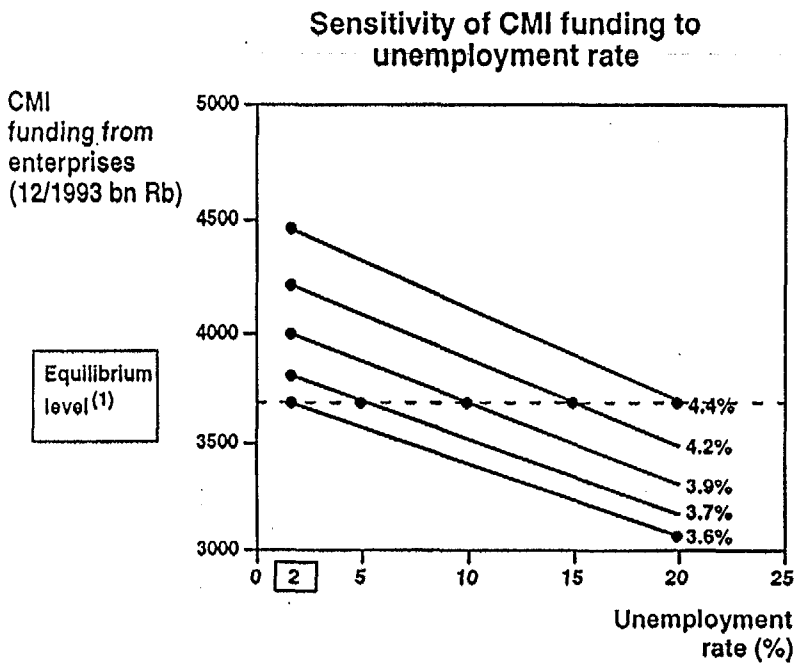
1 At 70% collection rate equilibrium shortfall would be 17%. To reach 1991 levels; local government would need to increase the health budget by 34%; or employers should contribute 7% of payrolls

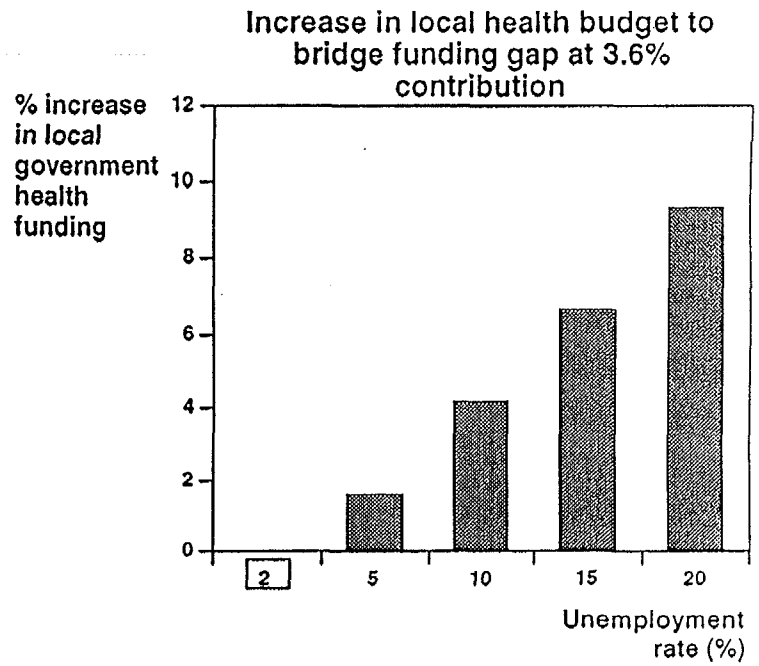
Note: Inflation adjustment based on monthly CPI

Source: Federal CMI Fund, World Bank, Goskomstat, BCG analysis

IMPACT OF UNEMPLOYMENT ON CMI FUNDS AND LOCAL BUDGET

To achieve 1991 equilibrium with unemployment of 10%, CMI rate would need to be 3.9% or local government spending increased by 4%





Note: 1. Based on equilibrium scenario and 1994 Q1 local government contribution for economically inactive
Source: World Bank, Federal CMI Fund, Goskomstat, BCG analysis

PRELIMINARY MODELLING IMPLIES THAT THE NEW FINANCING SYSTEM NEEDS AMENDMENTS

Preliminary modelling shows that the current financing system will not be able to bridge the gap with the 1991 reference level

There is a need for local governments to increase their level of health care expenditures. Their ability will be dependent on local economy and political situation

And / or there is a need to increase the CMI tax rate which must be put in perspective of the overall taxation of enterprises

The major unknown still is the availability of "informal" flows

- But polarization of the health care system is likely if a significant share of the funding is left to "informal" flows (only wealthy individuals would access adequate health care)

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THE REGIONAL FINANCING SYSTEM IS COMPLEX

The multi layer system generates structural complexity

- Local health authorities
- Local budgetary authorities
- CMI funds (with branches)
- Insurers
- Providers

The complexity is compounded by the lack of clear definition of the respective roles

- Unclear responsibilities for defining the strategy of the regional health care system
- Overlap of responsibilities
  - eg. a provider can be financed by both CMI funds and LHA for the same expenditures
  - quality control perceived as being part of the missions of Local Health Authorities and CMI funds even if insurance companies exist
- Some essential tasks not fulfilled
  - quality control and support to providers for operational improvement are rarely provided
- Ambiguous role of insurers
  - "cross-selling" of VMI and other insurance products

UNCLEAR ROLES ARE A KEY IMPEDIMENT SLOWING THE REFORM

The state of implementation of reform varies between regions

- In terms of players involved in the regional health system
  - very few insurance companies in some regions
- In terms of scope of expenditures covered by CMI funds vs local health authorities (providers type, # providers, urban vs rural)

The roadmap towards a stabilized situation is not clear

- Often no coordination between CMI funds and Local Health Authorities for transfer of responsibilities / funding
- Some exceptions : Moscow and Krasnoyarsk appear relatively successful in managing the transition

Important rivalry / distrust between Local Health Authorities, CMI funds and insurers

- However, in some regions, some individuals perform executive roles in both CMI funds and LHA

⇨ Major difficulties in funding for capital expenditures exacerbate the perceived difficulty of implementing the reform

OPERATIONAL EFFICIENCY VARIES GREATLY

Health care delivery efficiency

- Eg, annual cost per bed in hospital ranges from $3,000 to $11,000 in the regional sample

Health care financing efficiency

- Reported collection rate varies from 69% to 85%
- Commissions paid to insurers vary from 1.5% to 10% with similar scope
- Difficulty for CMI funds and for insurers to understand, and then to control, cost dynamics at the provider level
  - but interesting local projects underway (software packages in Tver)
- Limited benchmarks / standards
  - great variations in pricing of medical services
- Difficulty to use planning as a management tool due to unclear definition of roles and a lack of secure financing

OVERALL THE FINANCING SYSTEM DOES NOT ENCOURAGE EFFICIENCY

Both in terms of structural efficiency of the health care delivery organization

- No incentives to cut overcapacity in hospitals and polyclinics
  - compounded by providers' responsibilities for social services
- No incentives to allocate resources primarily to out-patient care
- Quality control and operational support to providers are not rewarded

And operational efficiency of the financing system

- The commission based financing of CMI funds and insurers doesn't create incentives to cut costs
- No direct pressure to reduce multiple layers of administrative costs with overlaps and redundancies

KEY PLAYERS PERSPECTIVE : SYNTHESIS (I)

Local CMI funds

Major concern about the stability of the sources of funds

- Can and will the budget funds finance economically inactive persons ?
- Economic instability affects enterprises' funding ability

The missions and scope of work are not very clear

- Which type of expenditures must eventually be financed through local government budget (eg, capital expenditures) ?

A couple of years will be necessary to get the system fully operational

Lack of management expertise / tools to control healthcare costs and quality

- Reimbursement methods
- Historical costs database / benchmark

Sometimes unwillingness to work with insurers

Concern about future role of Federal CMI fund and redistribution of all the funds (3.6% vs 0.2%)

KEY PLAYERS PERSPECTIVE : SYNTHESIS (II)

Local Health Authorities

Some reluctance to transfer financing and responsibilities to the CMI funds

Feel as having the leading role for quality control

Still favor discretionary allocation of funds

- Mostly for capital expenditures

Insurers

Some mixed feelings about the profitability opportunites of the CMI business (now and in the mid term)

Some view CMI as a major opportunity for products cross-selling

- Voluntary Medical Insurance products
- Other products

Lack of emphasis on cost and quality control

KEY PLAYERS PERSPECTIVE : SYNTHESIS (III)

Hospitals

Difficulty to perceive today the benefits created by the new system

- Still in the learning phase
- More effort required to get funds than in the previous systems (complex reimbursement procedures)

But opportunity to learn about cost management and some perception of increasing flexibility

Major capital expenditures shortfall

Insurance companies perceived as adding low value in the system

Concern about capacity cuts

Polyclinics

Concern about capacity cuts

- Medical staff
- Polyclinic closures

THE SYSTEM OFFERS SOME KEY OPPORTUNITIES FOR IMPROVEMENT IN THE NEXT YEARS

Decentralization allows for direct responsibilities and reactiveness in decision making

Today, the competition between the various players does not seem very active

- Many regions have a limited number of insurance companies (with local monopolies)
- Limited competition between providers since patients do not seem to exploit fully the freedom of choice when it is feasible

However, when the environment stabilizes regarding the implementation of the reform, market forces could largely improve the whole health care delivery and financing systems

- Mobility of patients and pressure from enterprises will force providers to improve quality or to exit
- Competition between insurance companies will force them to accept lower commissions and to play an active role in quality support

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TASK ORDER FOUR

FINAL REPORT

Annex 2 - Part 3

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February 28, 1995

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1885

Financing Health Care with
Particular Reference to Medicines

Volume 8

THE HEALTH CARE SYSTEM IN THE NETHERLANDS

n/e/r/a

National Economic Research Associates

May 1993

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CHAPTER 1
PROFILE OF THE HEALTH CARE SYSTEM

1.1 SUMMARY

- Structure

The health care system in the Netherlands is a system in transition. The current financing scheme is one of public funding through sickness funds (covering about two-thirds of the population) plus private insurance coverage for those with higher incomes (about one-third). Under the so-called Dekker reforms, approved by the government in 1988, this system will eventually be replaced by a centralised financing scheme. Private insurers and the sickness funds will attract enrollees by offering competitive premiums. Insurers will contract with providers to serve their enrollees. Providers will continue to be independent but will have greater incentives for efficiency under the new plan.

- Aggregate Expenditure

Historically, total spending on health care was determined by the demands of patients and the incentives on providers in treating patients. This led to unacceptably high expenditure which, in turn, resulted in increasing regulatory constraints. These included negotiated fees and capitations for physicians, attempts to limit physicians' incomes, constraints on capital spending by hospitals, prospective global budgeting for hospitals and reference pricing for pharmaceuticals. Given this heavy regulation, aggregate expenditure has become increasingly determined by political negotiations which try to balance public budgets against patient and provider satisfaction.

- Incentives

Primary Care Physicians: General Practitioners (GPs) are paid a capitation, or a fixed amount per year, for each public patient who registers with them. This encourages the GPs to pass patients to the hospital as soon as they begin to draw significantly on the GP's time and office resources, even when the least-cost site of care would be the GP's office.

Hospitals: The vast majority of specialists, or hospital-based physicians, are paid a fee-for-service which is negotiated for publicly insured patients. The incentive has been for them to provide low-benefit, high-cost services in the most expensive setting, the acute care hospital.

Since 1983, hospitals have been given a prospective, global budget in place of cost-based reimbursement, which had created strong incentives to increase costs. The newer scheme is meant to penalize hospitals which exceed their budget, essentially by forcing the hospital to make up the difference. This has not worked well. Hospitals do not control the utilization decisions of the hospital specialists or the GPs who send the patients to hospitals. Also, the hospitals have been able to increase their global budgets by obtaining approval to add equipment and capital which have, in turn, been used to justify higher revenues.

Funders: The sickness funds lack important efficiency incentives, largely because they are the monopoly public insurer for a large share of the local population. The reforms being implemented will force the sickness funds to compete with the private insurers. Private insurers have been successful in serving those who were not eligible for the public funds. The private sector has been able to select the lower risks in the population; so much so that the private sector makes a contribution to the public fund as payment for the adverse selection experienced by the sickness funds.

- Pharmaceuticals

As of January 1992, pharmaceuticals are being paid for under the Exceptional Medical Expense Fund (AWBZ) instead of the Health Insurance Act Fund. This reflects the ongoing implementation of the Dekker reforms which seek to roll all health care services into one central insurance fund. Other recent reforms have introduced the GVS programme, a 'reference pricing' scheme to pay for medicines. Under this scheme, patients must pay for anything in excess of a maximum reimbursement price. Supplemental insurance to help cover these copayments is apparently growing in popularity and should mitigate, to some extent, the negative impact of the GVS on the development of branded, patented drugs.

- Issues

The Dutch health care system has been characterized by significant inefficiencies, especially the lack of incentives to use least-cost alternatives in health care. This has created a large and expensive hospital sector and encouraged long lengths of stay and very little day surgery by comparison with other developed countries. Government attempts to control costs during the 1980s have stabilized spending as a share of GDP but have also reduced patient and provider satisfaction with the system. All of these factors underlie the recent passage of a major reform package to restructure the Dutch health care system.

- Reforms

The Dekker reforms are now being implemented in the Netherlands. The program has three main features: (1) one basic benefits package for all citizens under one financing scheme, with consumers choosing their insurer and the details of the insurance policy they most desire; (2) greater incentives for efficiency in the delivery of care; and, (3) a shift from government regulation to greater reliance on managed competition. Sickness funds and private insurers will compete for enrollees and receive a risk-adjusted premium for each enrollee from the single Central Fund. Each enrollee will pay a flat-rate (i.e., not risk-adjusted) premium that depends on the insurer and coverage plan of their choice. Funding for the basic benefits package will come largely from income-related taxes paid into the Central Fund (85 percent), with the remainder coming from the individual flat-rate premiums (15 percent) paid directly to the insurer chosen.

- Political Environment

The reforms are proceeding slowly despite widespread bi-partisan support at the time of passage. In addition to the technical complexities involved in finalizing the new schemes, there is growing political opposition to the proposed changes. Higher income groups generally object to paying more under a system funded by income-related taxes than they paid for private insurance premiums. Private insurers are less satisfied with the new system because a large share of their revenues will derive from a bureaucratic formula rather than being under their direct control. Consequently, many believe that full implementation will require as much as another decade.

1.2 STRUCTURE OF THE HEALTH CARE SYSTEM

1.2.1 The Health Care System in Context

The Netherlands is a constitutional monarchy. Legislative power rests with the Crown and the States-General (*Staten Generaal*) which has a 75 member upper house and a 150 member lower house. The upper house is indirectly elected by the twelve Dutch Provincial Councils for six years, with half its members being re-elected every three years. The lower chamber is elected by direct universal adult suffrage on the basis of proportional representation every four years.

There are 12 main political parties of which the most important are the Christian Democrats, Labour and the Liberals. All post World War II governments have been centrist coalitions, either Centre-Right or Centre-Left, and have always included the Christian Democrats. The most recent election for the lower house was in September 1989. The present government is a coalition of the largest party - the Christian Democrats - and the Labour Party.

The government has overall responsibility for most aspects of health policy in the Netherlands. However, the actual system is characterised by a public/private mix of finance, together with service provision from private, not-for-profit hospitals. Most doctors - both GPs and specialists - work as private practitioners. Many Dutchmen pride themselves on having developed a pragmatic 'mixed' health care system, combining the social responsibility of the British and Scandinavian public systems with the entrepreneurial efficiency of the United States.[1]

Expenditure on health care is high by international standards, and the standard of care is considered to be good. In general, patients have ready access to a comprehensive range of services and a wide choice between providers. Health status is also high. Life expectancy is long and infant mortality rates are among the lowest in the world.

Nonetheless, there are problems. The government has been particularly concerned with the rising costs of health care. Since the early 1970s, it has sought to control the growth in aggregate expenditure through price controls and by regulating the numbers of hospitals, hospital beds and new technologies. Overall, the results of these policies have been disappointing.[2] Total expenditure continued to increase at what was thought to be an excessive rate during the 1970s. These increases also led to increases in the share of income being spent on health care. As aggregate cost containment policies became more effective during the 1980s, other pressures emerged. Waiting lists for elective surgical procedures lengthened and there was a strike by physicians protesting about restrictions on their incomes. It became increasingly obvious that the

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1 Saltman and de Roo (1989).

2 van de Ven (1990).

system contained few incentives for using resources efficiently at the micro level. Moreover, some aspects of the mix of public and private funding were felt to be inequitable and to threaten social solidarity.

Faced with these shortcomings, the government appointed a committee to review the structure and financing of health care, chaired by Wisse Dekker, a former president of the electronics group, Philips International. The Dekker committee produced its report, "Willingness to Change", in March 1987. The Dekker plan had two main components: the introduction of a unified, basic health insurance package for the entire population; and the introduction of regulated competition between insurers and between providers. The proposals represent a movement towards a more market-based approach and are consistent with developments in a number of other countries and social policy areas.

After a lengthy and difficult decision making process, the cabinet presented its final response to the Dekker report in a policy paper, "Changes Assured", in March 1988. In this paper, the cabinet accepted the main lines of the Dekker approach. Following parliamentary debates, the first steps towards a new health care system were taken on 1 January 1989. It was expected that full implementation would take place over four years and would be completed by 1992. In fact, progress has been far slower than was originally envisaged. The proposals have encountered considerable political opposition, and doubts are now being expressed about whether they will ever be implemented in full.[3]

In summary, the Dutch health care system is in the throes of a major programme of reform. This represents an ambitious attempt to introduce incentives for greater efficiency while maintaining equity in terms of access to health care. At present, however, there are doubts about the extent and pace of change achievable.

1.2.2 General Features of the Finance System

According to official Dutch estimates for 1992, 9.4 percent of GNP will be spent on health care in the Netherlands.[4] This figure is higher than the OECD estimate of 8.3 percent (1989) mainly because it includes some long term nursing care expenditure not included by the OECD as health expenditure.

Finance is raised from three main sources. First, the entire population is covered by compulsory social insurance for the costs of serious illness or long-term disability under the Exceptional Medical Expenses (Compensation) Act, better known by its initials, AWBZ. Services covered include hospital stays in excess of 365 days, nursing home care, and services for people with physical disabilities, mental handicaps and mental illness. Revenue to meet the costs of AWBZ is derived from two sources: income-

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3 Elsinga (1989).

4 FOZ (1992).

related payments made by employees to the tax collecting authority; and (now only to a small extent) central government grants. In 1992, AWBZ is expected to account for about 45 percent of total health care expenditure.

The second source of health care funds is social insurance payments made under the Health Insurance Act. Everyone earning below a certain wage and salary level (set at 54,400 guilders in 1992 or $23,550 1990[5]) and recipients of social security benefits are required to contribute to this fund. These contributions include contributions related to earned income from insured people and their employers, and nominal flat-rate premiums. The over-65s remain covered after retirement if they were already compulsorily insured before retirement. Funds contributed under the Health Insurance Act cover the costs of GP services, short-term hospital care, dental care and, until this year, medicines. Approximately 62 percent of the population is insured under the Health Insurance Act. In 1992, it is expected to contribute approximately 24 percent of total health care expenditure.

The third source of health care funds is payments made directly by individuals (i.e., out-of-pockets payments) and payments made by private insurers on behalf of their insureds. These companies offer cover to the self-employed and to those individuals with earned incomes above the ceiling specified by the terms of the Health Insurance Act. Currently, there is a wide variety of private insurance packages varying in the extent of their coverage and use of copayments and deductibles. Employees often receive a contribution from their employers towards the costs of private health insurance but, unlike in the United States, most private insurance is taken out by individuals rather than by their employers. About 32 percent of the population is covered by private insurance arrangements.

Social insurance contributions are paid into a central fund administered by the Central Sickness Fund Board (*Ziekenfondsraad*). This board is an independent administrative body responsible for distributing funds to about 30 private, not-for-profit sickness funds, which operate on a regional basis, and to the private insurers (AWBZ funds only). The individual sickness funds are responsible for meeting the bills submitted by hospitals and other providers, including doctors' fees, for services received by insurees.

In addition to these three main forms of health insurance, there is a separate scheme for civil servants, covering about 6 percent of the population. Also, social care - particularly long-term residential care of the elderly - is funded separately through a combination of government grants and user charges.

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5 Throughout this Report, values are given in local currency and in 1990 US$. Conversions are made at 1990 Purchasing Power Parities. Further, figures in 1990 US$ are effectively equivalent to 1990 ECUs, for while the current $/ECU exchange rate is 1 ECU = $1.382 (Financial Times, 6 August 1992), Purchasing Power Parity suggests a rate of 1 ECU = $1.021. Source: OECD (1992a); OECD (1992b).

1.2.3 General Features of the Delivery System

In 1990, there were 120 general hospitals offering a range of short-term care. Most of these hospitals are run privately on a not-for-profit basis and each is managed by its own independent board. Many of these hospitals were developed by religious institutions. In addition, there were 36 specialised hospitals offering particular services, such as children's or ophthalmic services, and 9 teaching hospitals attached to universities, in which the training of doctors and medical research took place.

Despite the private status and autonomy of Dutch hospitals, they have all been subject to strong regulation under national planning legislation. They have not been permitted to expand or alter their activities without government approval. In general, approvals have only been granted if proposed changes conform with a hospital plan that has been drawn up by the local government and ratified by the national government.[6]

Long-term care is provided in 83 psychiatric hospitals, 121 homes for people with mental handicaps and 325 nursing homes.

Family doctors (GPs) and most specialists are self-employed, private practitioners. The specialists are licensed to practise in the hospitals in which they work. As with hospitals, doctors' activities are subject to regulation by government. Until this year, local authorities had the power to restrict the establishment of new GP practices in areas in which their numbers exceeded a specified norm. This restriction has been recently abolished. There are still, however, norms regulating the number of medical specialists.[7]

In 1990, there were 1,453 pharmacists and, in addition, just over 700 doctors who had pharmaceutical facilities (from a total of 6,573 GPs).

1.2.4 Inputs and Outputs of the System

During the period of 1987 to 1992 Dutch health care expenditure as reported in the Financial Overview of the Care Sector (FOZ) by the Ministry of Health increased from 42.9 bn guilders to 52.6 bn guilders (from $19.6 to $21.3 bn 1990). This corresponds to 10.0 percent of gross national product (GNP) in 1987 and 9.4 percent in 1992.[8] These expenditure figures, both in absolute terms and expressed as a percentage of GNP, are somewhat higher than those reported by the OECD for the Netherlands. The major reason for this discrepancy is that OECD figures do not include long-term residential

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6 VNZ (1990).

7 VNZ (1990).

8 Figures for 1992 are estimates.

care of the elderly. Both sets of data indicate that expenditure as a proportion of GNP has fallen over the period.

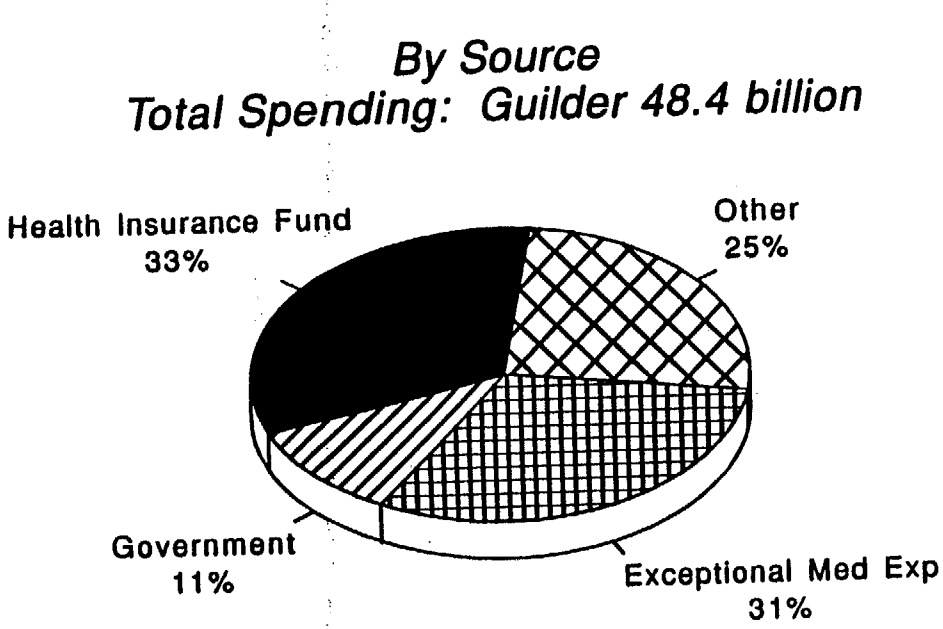
Chart 1.1 indicates the sources of health care finance and the distribution of health care costs between the main sectors for 1990. Hospital care and the services of medical specialists (usually provided within hospital settings) account for nearly one-third of total expenditure. This is almost double the share of expenditure devoted to ambulatory care. In fact, the predominance of hospital services is a notable feature of the Dutch health care system. Bed days per person and average lengths of stay are both high by international standards.[9]

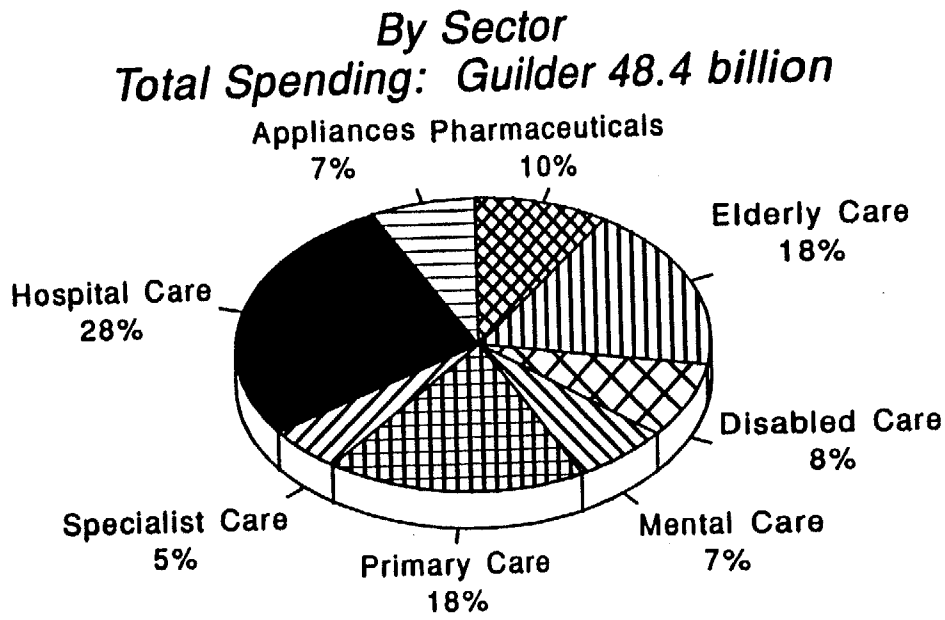
The number of general hospital beds fell steadily over the period 1986-90 as did the beds per 1,000 population ratio, mostly in response to cost containment regulation. Over the same period, the number of GPs grew by 4.6 percent, while the number of medical specialists increased by 16 percent.

Selected health status indicators indicate that life expectancy for both sexes and at all ages are among the highest reported by OECD countries. Favourable health status is also indicated by very low infant mortality and crude mortality rates, although the Netherlands is in the bottom one-third of OECD countries in terms of its perinatal mortality rate.

[9] OECD (1991).

Chart 1.1
Expenditure on Health Care in the Netherlands, 1990





Source: FOZ, 1992; Association of Dutch Health Insurers, 1991

1.3 ANALYSIS OF INDIVIDUAL SECTORS

1.3.1 Key Participants in the Health Care System

The main participants within the health care system in the Netherlands that are discussed in this section are:

- patients;
- financing organisations;
- providers of primary and community health care services;
- providers of hospital services; and,
- pharmaceutical sector.

The relationships between these participants, and the flows of finance and services between them, are described in Chart 1.2.

1.3.2 Patients

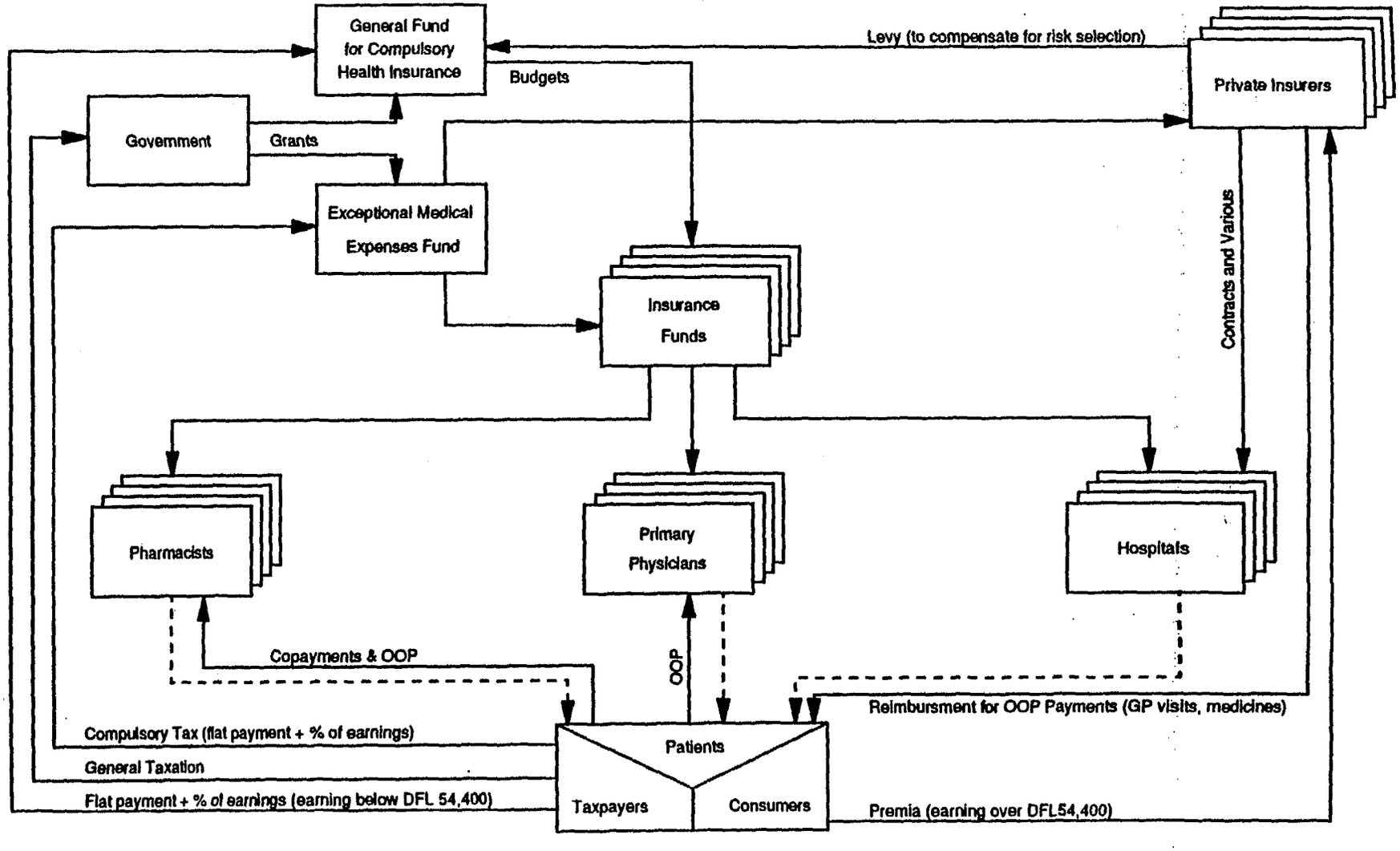
Health care services in the Netherlands originated largely from private initiatives, often on a charitable basis. Although the role of philanthropy has been gradually replaced by public finance and government regulation over the years, the system is still based upon a high degree of individualism. It is not a 'socialised' system in the same sense as the British National Health Service. One manifestation of this approach is that 'rights' are rarely discussed in the health care context in the Netherlands. Rather, discussion usually focuses on 'obligations' and the ways in which different participants in the health sector are bound together by mutual, interlocking obligations.[10] Nonetheless, the concept of 'social solidarity' does figure prominently among the objectives set for social policy in the Netherlands, as in many other European countries. This is generally taken to mean that contributions to the total costs of health care should be on the basis of ability to pay and that access to essential services should be based upon some definition of need.

Since the introduction of insurance benefits under the Exceptional Medical Expenses Act and the Health Insurance Act in the 1960s, the Dutch have become accustomed to wide access to a high standard of service. There is considerable choice between GPs and hospital specialists, and care provided under social insurance is generally free at the point of service. There is a high level of public satisfaction with the health care system, as reported in a recent ten-nation survey.[11] On the basis of a sample of 1,000 Dutch residents surveyed in 1990, the Netherlands emerged as second only to Canada in terms of the proportion of the sample (47 percent) who felt that "the health care system works pretty well and only minor changes are necessary to make it work

[10] Kirkman-Liff (1991).

[11] Blendon et al. (1990).

Chart 1.2
Key Participants in the Health Care System in the Netherlands, 1991



Financial Flows
Service Flows

better." The same survey showed that nearly the same proportion of the sample (46 percent) thought that "there are some good things in our health system, but fundamental changes are needed to make it better." Only 7 percent believed that the system should be entirely rebuilt.

Certainly there is evidence of dissatisfaction with certain aspects of the system. In particular, attempts to control the growth of aggregate expenditure have resulted in waiting lists for some services; these include care of the chronically sick, organ transplants, and orthopaedic and ophthalmic services. The real costs of waiting lists are significant. Silver Cross (a private insurer) estimates that 20 percent of absenteeism from companies in the Netherlands is caused by waiting times in health care services. As a result, Silver Cross has developed insurance packages which include 'accelerated treatment programmes.' These programmes allow privately insured patients to be treated in local hospitals without joining the waiting list. In urgent cases Silver Cross guarantees treatment, even if the patient must be sent outside the country.[12]

Cost containment through reductions in hospital capacity and restricting physician services have been politically unpopular. There has even been a strike by physicians protesting at attempts to control their income. At the same time, there is a widespread view that the health care system harbours X-inefficiency; that is, costs are higher than they would be if providers and sickness funds were being subjected to competitive pressure. A majority of the public (50 percent) believe that a 10 percent cost saving could be achieved with no decline in quality, and 20 percent believe that a 20 percent cost saving could be achieved with no decline in quality.[13]

1.3.3 Payers

1.3.3.1 The Exceptional Medical Expenses Act (AWBZ)

The Exceptional Medical Expenses Act came into force in December 1967 and phased implementation began in January 1968. The scope of the Act is considerable. Initially it served mainly as a means of funding long-term or high-cost care, but over the years its provisions have been extended to cover more elements of health care, many of which are neither prolonged nor expensive in nature. In the future, coverage under the Act will be extended so that eventually it represents a basic insurance scheme covering the great majority of health and social services for the entire population. In 1992, AWBZ is expected to cover about 45 percent of all health care expenditure, up from 31 percent in 1991. This reflects the reform plan's shift of coverage for some health services (notably, pharmaceuticals) from the Health Insurance Act into the AWBZ fund.

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12 Overmars (1992).

13 Kirkman-Liff and van de Ven (1989).

Coverage under the Exceptional Medical Expenses Act includes:

- treatment and care in hospitals after the first 365 days;
- treatment and care in psychiatric hospitals and psychiatric wards;
- nursing home care;
- care in an institution for the mentally handicapped;
- care in an institution for the deaf and those with partial hearing;
- services for the blind and poorly sighted;
- vaccinations;
- services for the disabled including day centre and hostel care;
- day care in a nursing home;
- home-care services;
- psychosocial care;
- psychiatric out-patient and non-residential care;
- medicines; and,
- aids and protheses.

Insurance under the Exceptional Medical Expenses Act is statutory; practically the entire population is covered and must make both income-related and flat-rate contributions. In 1992, the income-related contribution rate is 7.3 percent of income (to a maximum income level) and the flat-rate contribution is 133.2 guilders ($53.81 1990) per adult and 44.4 guilders ($17.94 1990) per child up to the age of 18 years (for a maximum of two children).

In addition to the funds provided by individual contributions, part of the costs of AWBZ are met by a central government grant. However, as a result of government funding constraints, the size of this grant has fallen considerably over recent years and is now very small.

The contributions collected by the tax authorities, together with the government grant, are paid into the Exceptional Medical Expenses Fund. This is administered by the Central Sickness Fund Council (*Ziekenfondsraad*) which makes payments to individual sickness funds and private insurers. It is these funds and insurers that are responsible for paying the bills for health care services provided under AWBZ. They are also responsible for organising payments for services covered by the Health Insurance Act.

1.3.3.2 The Health Insurance Act

The Health Insurance Act came into force on 1 January 1966. This provides a financing scheme for basic medical and hospital care for about 62 percent of the population. Under the provisions of the Act, everyone meeting the criteria set by the legislation is automatically insured and must pay the statutory contributions. The most important criteria is that the individual's wage or salary is below a specified ceiling, set at 54,400 guilders in 1992 ($23,550 1990). In addition to the employed, this includes the unemployed, disabled and pensioners.

Coverage under the Health Insurance Act includes:

- medical and surgical treatment by GPs and specialists;
- obstetric care;
- dental care;
- hospital care;
- transport;
- maternity care;
- audiological services;
- haemodialysis;
- services for patients with chronic respiratory problems;
- non residential rehabilitation services;
- services of a thrombosis unit; and,
- genetic testing and counselling.

There is some regional variation in the percentage of the population covered under this scheme, ranging from 56 percent of the population who are covered in the province of Utrecht to 68 percent of the population in Limburg.

Contributions for those up to the age of 65 are related to their income, whether this is earned income or income from social security. Until the end of 1988, employers and employees (or the relevant social security organisation) were each required to make payments of about 5 percent of the insured's income. However, from the beginning of 1989, contributions ceased to be entirely income-related; a part of the insured's contribution is now a flat-rate charge and so the income-related part of their contribution has been reduced. Under the Dekker reforms, the transfer of coverage for some benefits to AWBZ has also served to reduce the income-related payment. In 1992, the combined employee/employer contribution amounted to 6.35 percent of the insured's income, with a flat-rate payment of 198 guilders ($80 1990) per adult and 99 guilders ($40 1990) per child up to the age of 18 (for a maximum of two children).

The over-65s and people who have taken early retirement are subject to special arrangements. Reduced rate income-related contributions (0.75 percent in 1992) are payable from that part of their incomes which is related to the Old Age Pensions Act. Additional retirement income is charged at the full rate payable by employed people. The retired are also required to pay the flat-rate charge.

Contributions from employers and employees cover about 85 percent of the cost of benefits provided under the Health Insurance Act. The remainder is covered by government grants (about 10 percent) which were originally used to cover some of the costs of services for the elderly before they were incorporated into the Health Insurance Scheme in 1986, copayments (4 percent) and payments from private insurers (1 percent). The payments from private insurers are required to meet some of the public sector costs arising from adverse selection. This occurs because old people are over-represented within the Health Fund Scheme compared with the private insurance

sector. In order to meet the extra costs arising from this imbalance, legislation was introduced requiring the private sector to make a contribution towards the costs of compulsory health insurance, as long as old people remain over-represented within the compulsory scheme.

All of these funds are paid into the General Fund for Compulsory Health Insurance. This fund is managed by the Sickness Fund Council, which makes payments to individual sickness funds. Thus, the individual sickness funds are responsible for organising payments under both the Exceptions Medical Expenses Act and the Health Insurance Act.

The sickness funds are regionally based. Table 1.1 lists the funds that were operating in January 1988, their location and the size of population covered by them. Since 1988, there has been a reduction in the number of funds through rationalisation and amalgamation. It is expected that eventually there will probably be only 10 to 15 funds.

Because it is the individual sickness funds that are responsible for making payments to health care providers, they are in a key position - as third party purchasers of care - to influence the efficiency with which the care is provided. In fact, there is a certain amount of evidence to suggest that they have not been particularly vigilant in this respect. One reason may be that sickness funds operate as local monopolies and so there is little competition between them for subscribers. A study of the financial reports of 40 sickness funds reveals a variation in *per capita* expenses between the lowest-cost and highest-cost fund of 69 percent. Standardising for the age-sex composition of their insurees accounts for only about one-third of this variation, suggesting that there are large unexplained differences in management efficiency.[14]

The current reform programme (discussed in Section 1.5) aims to address this problem by introducing competition between insurers. It would be incorrect, however, to suggest that none of the individual funds has been active in encouraging efficiency to date. Kirkman-Liff and van de Ven (*op cit*) describe a number of initiatives which have sought to encourage greater efficiency among providers. Many of them concentrate on the role of GPs as 'gatekeepers'. Traditionally, the capitation payment system has offered little incentive for GPs to develop services for their patients. There has been an incentive for GPs to refer their patients to hospital specialists at an early stage. This decision is costless to them and avoids the costs of managing patients themselves. Thus, patients are shifted from a low-cost site of care to a high-cost site. Various sickness fund demonstration projects have sought to counteract these perverse financial incentives.

[14] Kirkman-Liff and van de Ven (1989).

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TABLE 1.1: SICKNESS FUNDS, 1988

Name	Place	Population
Noord Holland Noord	Alkmaar	313,120
Amersfoort	Amersfoort	180,335
Amstelveen CZH	Amstelveen	407,650
Amsterdam ZAO	Amsterdam	472,255
Apeldoorn en Omstreken	Apeldoorn	71,020
MZB	Bergen op Zoom	100,175
AZWZ	Breda	317,680
Zuid-Hollandse Eilanden	Brielle	111,440
DSW	Schiedam	207,385
Salland	Deventer	75,200
Drechtstreek	Dordrecht	122,635
Eindhoven en Omstreken	Eindhoven	177,815
Ziekenfonds OGZO	Goor	110,770
Gorinchem en Omstreken	Gorinchem	66,735
Gouda-Woerden	Gouda	132,600
Haaglanden	Den Haag	314,435
Azivo	Den Haag	93,185
Spaarneland	Heemstede	198,575
RZG	Groningen	357,655
Mijnstreek	Heerlen	207,165
Twente	Hengelo	354,990
Het Gooi en Omstreken	Huizen	164,885
Leeuwarden-Sneek	Leeuwarden	69,295
Leeuwarden-APFZ	Leeuwarden	228,470
Leiden-Alphen	Leiden	176,495
Zuid-Limburg ZZL	Maastricht	101,740
Drenthe Noord-Overijssel	Meppel	395,660
Midden en Noord Zeeland	Middelburg	128,910
Nijmegen BAZ	Nijmegen	136,585
Purmerend	Purmerend	171,525
Rotterdam SZR	Rotterdam	445,305
Sittard	Sittard	254,345
Tilburg Centraal CZT	Tilburg	512,130
Midden-Brabant ZMB	Tilburg	392,620
Midden-Nederland RZMN	Utrecht	400,095
Rijn-IJsselland RZR	Doorwerth	483,815
Noord-Limburg ZNL	Venlo	158,170
Zwolle RZZ	Zwolle	173,110
Apeldoorn ANOZ	Apeldoorn	
Friesland ANOZ	Leeuwarden	
Lingestreek ANOZ	Leerdam	275,736
Ijsselstreek ANOZ	Zutphen	
Nijkerk ANOZ	Nijkerk	

Several sickness funds have invested substantial effort in improving their medical care monitoring systems. These systems typically provide individual physician data on referral rates, prescriptions for medicines and the use of diagnostic services. They enable medical advisors from the sickness funds to meet with individual GPs to discuss their performance. Moreover, various combinations of performance payments and elements of fee-for-service have been introduced in order to reduce unnecessary referrals to hospitals, to stimulate GPs to undertake more minor surgical procedures themselves and to encourage them to take on greater responsibility for long term care, such as diabetes control.

There has also been a collaborative effort between Silver Cross (the largest private non-profit insurer in the Netherlands), a regional sickness fund in Utrecht and a community health centre to develop a limited provider plan. This incorporates elements of a US-type health maintenance organisation with some of the hospital and specialist referral aspects of a preferred provider organisation.

Elsewhere, sickness funds have successfully developed programmes for Area Clinical Pharmacologists, in collaboration with medical schools. Under these arrangements, physician-pharmacologists work for the sickness funds and meet with general practitioners to discuss pharmaceutical issues. This often involves the development of prescription protocols for more cost-effective use of high-cost medicines.

Despite these initiatives, however, Kirkman-Liff and van de Ven believe that there is still major scope for sickness funds to strengthen the roles of their medical advisers and other staff involved in utilisation management and quality assurance. They cite use of prior authorisation for major diagnostic and therapeutic procedures in the United States, as well as concurrent review and discharge planning during inpatient stays, and claim that these activities could similarly encourage greater use of clinically-appropriate and cost-effective care in the Netherlands. They also claim that an alternative to introducing fee-for-service elements into general practice would be to reduce GP patient list sizes and offer higher capitation payments in return for active GP participation in quality assurance and utilisation review procedures.

1.3.3.3 Private Insurers

People earning over the income limit of 54,400 guilders in 1992 are not eligible for coverage for basic medical and hospital care under the Health Insurance Act. Most of these people take out private insurance plans with one of the more than 40 private insurers. Just over 5 million people, or 32 percent of the population, are insured in this way. About 60 percent of private insurance is taken out in the form of individual contracts, and 40 percent are group contracts. There is considerable variation among the contracts in terms of their coverage, the choice offered between providers and the use made of copayments and deductibles.

Many of the companies offering health insurance are multi-sectoral firms offering insurance in other areas in addition to health care. In recent years, there have been a number of joint ventures between private insurers. In 1989, for example, two alliances were formed by eleven of the largest private health insurers, accounting for half of the private health insurance market. Because the regional market share of private health insurers is generally low, joint ventures and mergers are seen as a way for them to develop countervailing bargaining power in relation to providers.[15]

Although the private insurers serve individuals not covered by the Health Insurance Act, their activities are not always entirely separate from those of the sickness funds. There is some joint ownership. Although formal mergers between private insurers and sickness funds are not possible at the moment, one private insurer already offers supplemental insurance business for six sickness funds. (Under the reform proposals, direct mergers will be possible - see Section 1.5).[16]

Moreover, the largest private health insurer in the Netherlands - Silver Cross, which has 650,000 subscribers - was actually founded in 1948 as the result of an initiative taken by the sickness funds. The funds were concerned about the fate of their members whose incomes reached the ceiling level and could therefore no longer be insured with them. Silver Cross was developed to offer good quality services to these groups at a reasonable price. Subsequently, Silver Cross has taken the view that insurers need to be more active in the organisation and management of care and has developed the 'Silver Care' concept as an example of managed care based upon the US health maintenance organisation model.[17]

1.3.4 Primary Health Care Sector

Primary health care in the Netherlands is based upon a system of general practice doctors (GPs) who are usually the first point of contact for people with health problems. Dutch GPs are independent contractors with the sickness funds, in much the same way that British GPs are independent contractors with the National Health Service.

In 1989 there were approximately 6,200 GPs with an average of 2,350 patients each. More than half of all GPs (54 percent) are in individual practices; 38 percent work in partnerships, usually comprising two GPs; and a small minority (7 percent) work in integrated health centres alongside community nurses and social workers. Until 1992, doctors who wanted to establish a separate general practice were required to obtain a permit from the relevant municipal authority. Permits were issued based upon the GP

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15 Schut et al. (1991).

16 Schut et al. (1991).

17 Kamermans et al. (1991).

per capita ratio and the spatial distribution of practices. In 1992 this system is being abolished and GPs will be able freely to choose the location of their practices.

The overall number of contacts with GPs is estimated at 4.2 per patient per year; of these, 3.2 are with the GP and the remainder with the practice secretary. Of the contacts with GPs, 17 percent take the form of home visits.[18]

GP's patients may be divided into two categories on the basis of their insurance status. First, there are those whose services are publicly insured under the Health Insurance Act. These patients can choose to be registered with the GP of their choice. The GP currently receives a flat capitation fee (not related to age or other patient characteristics) for each patient. The capitation covers only primary care services and the GP is not at financial risk for referral to hospitals or specialists. (In the future GPs will negotiate reimbursements with insurers.) Second, there are patients covered by private insurance. Some of these will have policies which include the costs of primary care. Privately insured patients generally pay their GPs per consultation and claim partial payment from their insurance companies if covered for this service.

Publicly insured patients can only obtain access to specialist and hospital care on the basis of a referral from a GP. Most private insurers also require a GP referral. GPs are, therefore, in a strong position as 'gatekeepers' to secondary care. To date, their financial incentives have been to shift patients into secondary care too quickly. Under the proposed reforms, these incentives are expected to change.

Primary or community health services are also provided by about 7,000 community nurses. The work of community nursing is concentrated in two main areas: namely, well-baby care and nursing care, mainly for elderly people. Most of this work takes place in the patient's own home. The service is organised on a national basis through 70 regional organisations and their constituent local teams, usually comprising a head nurse, seven registered nurses and two unregistered nurses. These local teams usually work within a restricted geographical area, unlike GPs who often serve scattered populations. A small number of community nurses work in integrated health centres alongside GPs and social workers.

In contrast to many other countries, patients in the Netherlands have direct access to the services of community nurses. About half of patient contacts are made in this way. The remainder come from GP recommendations (about one-fifth) and from nursing home and hospital referrals (about one-third).[19] Since 1980, the services of community nursing have been insured under AWBZ, although a membership fee is often required. The membership fee reflects the origins of the service which began through voluntary organisations.

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[18] Groenewegen (1991).

[19] Groenewegen, (1991).

Two other groups which contribute to the provision of primary and community care are family assistants and general social workers. Family assistants are organised within a large number of local or regional organisations. There are approximately 35,000 family assistants providing housekeeping, personal care and social support, primarily for elderly people living alone. The service is funded, as with community nursing, through AWBZ, although people have to pay part of the costs themselves, based upon their personal financial circumstances. The service is important because it enables people to live on their own, delaying admission to nursing homes or homes for the elderly, or bridging waiting times for admission to these institutions.

Social workers are in the salaried service of social work organisations, although they often work closely with family assistance organisations. In 1989, there were 2,000 general social workers usually providing assistance for those with psycho-social problems. They provide a major source of help for low income groups in need of mental health services. General social work is directly accessible to patients without any copayments. The costs of the service are met through municipal subsidies. The service is notable for being the only area of primary care where finance has been successfully decentralised.

Co-ordination between the various providers of primary and community care is achieved through bilateral cooperation, through loosely structured primary care teams ('home teams') and through integrated health centres. Home teams involve co-operation between a GP, a community nurse and a general social worker with regular consultations about patients and their needs. In 1989, there were 460 home teams, comprising one-quarter of all GPs, one-fifth of community nurses and two-fifths of general social workers. Health centres involve at least one GP, a community nurse and a general social worker working together in shared premises. In 1990, there were 160 health centres. They are mainly located in new towns or in new parts of towns where health care services have been built up from scratch. Relatively few have been formed by joining together existing services.

1.3.5 Hospital Sector

The hospital system in the Netherlands reflects the complicated political and religious history of the country. Many social institutions were organised either confessionally (Catholic and Protestant denominations) or politically (socialist and liberal parties). These have been referred to as the 'four pillars' of society, each seeking to maintain its own cultural identity.[20]

Although the decline of the 'pillar system' over time has led to mergers and joint ventures between different institutions, the basic landscape remains largely defined by confessional and/or political affiliations. Thus, the majority of the country's 250 hospitals are religious in character, although about 40 of them were established and are

[20] Saltman and de Roo (1989).

operated by municipal governments. All of these hospitals are owned and operated predominantly by private, locally-controlled, independent boards on a not-for-profit basis. In fact, private for-profit hospitals are prohibited by law in the Netherlands.

Government policy aimed at reductions in hospital excess capacity has led to the active encouragement of mergers between hospitals, and to a steady reduction in the total number of hospitals over time. Between 1986 and 1990, for example, the number of general hospitals fell from 143 to 120 separate institutions. Some researchers question the wisdom of this policy and claim that it likely to stifle competition.[21] However, the government seems to believe that larger hospitals offer economies of scale and that mergers are politically the most effective way of eliminating excess bed capacity.

Most hospital specialists work for themselves as independent practitioners. There are a small number of specialists working on a salaried basis in teaching and municipal hospitals. Despite their independent status, however, the majority of hospital specialists are now organised in group practices known as partnerships, usually comprising three to six members. When a new specialist enters a group, a 'goodwill' fee, usually amounting to between one and one-and-a-half times the specialist's annual gross income, is payable to the group.

Specialists are paid on a fee-for-service basis. For sickness fund patients, a detailed fee schedule is negotiated between the Association of Sickness Funds (VNZ) and the National Association of Specialists. This schedule is based upon a norm, or target income, for doctors within each specialty, which is also negotiated nationally. Payment involves a sliding scale of fees - known as 'regressive fees' - on the basis of which payments per item of service fall as the number of services provided exceeds specified limits. However, attempts to restrict specialists' incomes to target levels have been largely unsuccessful, because there is no co-ordinating system for aggregating income earned from sickness funds and private insurance companies. The available evidence indicates that doctors compensate for reductions in fees by increasing their workloads to achieve target incomes they set for themselves rather than those specified in national negotiations.

Hospitals are required to break even after taking account of all of their costs and revenues. There have, however, been some major changes in the financial arrangements governing hospital behaviour in recent years. Prior to 1983, hospitals received full retrospective reimbursement for all of the services they provided. It was an open-ended arrangement. Taken together with the fee-for-service system under which doctors were paid, there were powerful incentives to maximise the number of inpatient days. This was achieved both by high admission rates and long lengths of stay. There were few incentives to contain aggregate expenditure or to strive for efficiency at the micro level. Government attempts at cost containment were pursued

[21] Schut et al. (1991).

through regulation of capacity and through attempts to control tariffs. Neither mechanism was considered to be particularly successful.

A major effort to address these shortcomings was launched in 1983 when retrospective reimbursement was replaced by a regime of prospective global budgeting. Under this system, each hospital received a prospective budget limit for the following year. It was intended that any over-expenditure would be met by the hospital itself and that the prospect of this penalty would encourage greater cost consciousness.

Considerable effort has been devoted to the task of devising a formula for setting hospital budgets. In the early years, individual hospital budgets were simply set on the basis of historic expenditure levels. Clearly, this did not distinguish between efficient and inefficient providers. The first attempt to address this problem was taken in 1985, when a formula was introduced which sought to identify acceptable cost levels with more precision. It did this by distinguishing between fixed and variable costs. Budgets for fixed costs are based on fixed inputs such as the number of beds and the number of specialist units within a hospital, whereas variable costs are based on variable inputs such as admissions and patient days.

The second major revision to the budgetary formula was the introduction of functional budgeting in 1988. Functional budgeting is based on the principle that hospitals should receive the same budget for performing the same function. Three main factors were taken into account in order to determine the functional budget:

- the size of the population served by the hospital;
- approved hospital capacity measured in terms of bed numbers and specialist units; and,
- 'production agreements' between local insurers (sickness funds and private insurers) and local hospital boards.

This process was expected to lead to a large re-allocation of budgets between hospitals, but was also expected, in the longer term, to increase efficiency incentives in the hospital sector.[22]

It is not clear that prospective budgeting has achieved the results expected, either in terms of aggregate cost containment or greater efficiency. A case study of two 500-bed hospitals carried out in 1987 sheds some light on the limitations of these budgetary controls as a cost containment device.[23] The study showed that for the two hospitals concerned, their budgets grew by 15-17 percent over the period 1983-1987 rather than

[22] Maarse (1989).

[23] Saltman and de Roo (1989).

falling by the 7 percent that official policy required. This occurred because, faced by budget limitations, the hospital managers responded by aggressively pursuing new capital investments - for which revenues were automatically approved - and by developing 'off-budget' activities beyond the regulator's grasp.

Another reason why prospective budgeting appears to have had limited impact upon the efficiency with which resources are used in hospitals is because effective internal management arrangements with hospital specialists have rarely been developed. External cost constraints may act as a stimulus for more effective hospital management but, if it is to be implemented successfully, it requires clinicians to be actively involved in the management of resources. Despite some experiments with clinical budgeting at university hospitals in Maastricht and Utrecht, for example, most medical staff have not been fully integrated into the management of services. Indeed, some researchers emphasise the independence of hospital specialists and the unwillingness and/or inability of managers to challenge their autonomy.[24]

One specific source of rising costs in the hospital sector that the Dutch government has been concerned with is the introduction of new technologies. In fact, with the exception of open heart surgery, the Netherlands does not have particularly high treatment rates in procedures using expensive new medical technologies. Similarly, expenditure on drugs and medical equipment is not excessive. Nonetheless, as in most other countries, there is concern about the impact of new diagnostic and therapeutic procedures on health expenditure.

With individual sickness funds facing few incentives for purchasing cost-effective care, most of the onus for controlling the diffusion of new technology has traditionally been assumed by the government. The Hospital Provisions Act provides two regulatory measures for pursuing this aim. Article 3 gives the government the power to control the distribution of medical specialists in the hospital sector. This can be relevant when new technologies are related to specialist functions. More directly, Article 18 gives the Minister of Health the authority to control, by licensing, the provision of certain services involving new technologies. Ten technologies have been licensed under this authority; namely, kidney dialysis, kidney transplantation, radiotherapy, neurosurgery, cardiac surgery, heart catheterisation, nuclear medicine, computed tomography, pre-natal chromosome examination and neo-natal intensive care.

More recently, the realisation that the causes of increased health care expenditure seem to lie in the more widespread use of 'common' technologies (rather than simply the introduction of new technologies) has led to an increased interest in providing incentives for cost-effective care, rather than placing reliance upon administrative regulation. Recent changes in hospital budgeting falls into this category, as does the decision of the Sickness Fund's Council, in 1987, to designate certain technologies as 'emerging' and to approve them for reimbursement only following evaluations.

[24] Saltman and de Roo (1989); van de Ven (1991).

Various transplant procedures, lithotripsy and in-vitro fertilisation were all designated as emerging technologies. Rutten and Banta (1988) argue that overall there is a growing belief that incentives are more powerful than regulation in achieving a cost-effective use of new technologies.

The development of an appropriate incentive system does rely upon the existence of accurate information on the costs and benefits of existing and new technologies. Despite an active academic community that is engaged in this work in the Netherlands - and a community which, moreover, has strong links with health policy officials - there is still an extremely limited institutional base for technology assessment. Given that the country imports about 90 percent of its technology, Rutten and Banta suggest that there is need for a clearing house that will be able to access international information.

1.3.6 Pharmaceutical Sector

The Ministry of Welfare, Public Health and Culture has broad responsibility for pharmaceutical affairs. The Pharmaceutical Inspectorate, which is part of the State Health Inspectorate, is responsible for ensuring that regulations are complied with, and for advising the Ministry.

All registered pharmaceuticals are divided into two categories; namely, prescription only (*Uitsluitend Recept, UR*) and pharmacy only (*Uitsluitend Apotheek, UA*) products. A limited number of pharmacy only products are sold on a non-prescription basis and smaller pack sizes (list V products) are available from non-pharmacist druggists.

The main outlet for prescription medicines is through retail pharmacies. These pharmacies must be owned by a pharmacist or a co-operative of pharmacists. Most retail pharmacies are members of the Royal Netherlands Pharmacy Society (KNMP). KNMP members may run only one pharmacy. However, some non-KNMP pharmacy chains have been set up. There are no regulations covering the location of retail pharmacies, although the KNMP produces voluntary guidelines. There were 1,423 retail pharmacies in 1990 according to the Central Bureau of Statistics. The State Health Inspectorate inspects these pharmacies.

In addition to these retail pharmacies, there were 758 dispensing doctors in 1990. Doctors are permitted to dispense in areas with no pharmacy but lose this right when a pharmacy is authorised in their district. In recent years, the number of dispensing doctors has fallen as the number of retail pharmacies has grown. The Ministry of Welfare, Public Health and Culture seeks to encourage a rational distribution of retail pharmacies and dispensing doctors.

Druggists sell List V products, as well as non-pharmaceutical items such as cosmetics. There are over twice as many druggists as there are retail pharmacists and these tend to be preferred by many customers.

Other outlets for medicines are hospital pharmacies and a limited number of grocery stores which are registered to sell a restricted list of medicines. A hospital must have more than 300 beds in order to have its own pharmacy, otherwise it must rely upon local retail pharmacies.

The pharmacists' association publishes an official price list for pharmaceuticals which is used by the sickness funds and private insurers as a basis for reimbursement. Apart from encouraging some voluntary price freezes, the government has not sought to control these prices directly and, no doubt partly as a result of this, prices in the Netherlands have been high by international standards. Figures reported by Burstall (1991) show that they were nearly 30 percent above the EC average. Patients have been expected to meet about 20 percent of the cost of pharmaceuticals in the form of copayments.

High price levels in the Netherlands in comparison with other European countries makes the practice of parallel importing profitable. In fact, the government actually looks favourably upon the practice viewing it as a useful way of keeping total expenditure in check. To this end, it allows retail pharmacists to retain one-third of the savings made through the use of parallel imports. Burstall (1991) notes that it is not clear whether this is legal under the terms of the Treaty of Rome.

Government attempts to reduce overall expenditure on medicines have a long tradition in the Netherlands. In 1982, the government introduced three limited lists. The Sickness Fund Council also seeks to influence prescribing through a pharmacotherapeutic guide which lists the names of all pharmaceuticals available on the market with a description and assessment by the Central Medical Pharmaceutical Committee in terms of their efficacy, indications, contra-indications, side-effects and price. The guide indicates products not recommended for prescription (because of their therapeutic value or price), new products not yet assessed for reimbursement, and also lists recently withdrawn products. It also contains products included in the Dutch National Formulary.

In fact, the volume of consumption of medicines *per capita* in the Netherlands is very low by international standards (about half the EC average). Thus, although pharmaceutical prices are relatively high, overall expenditure on medicines is relatively low. Only about 5.3 percent of total health care expenditure was devoted to medicines in 1987 compared with an EC average of 10.1 percent. There has, however, been an increase in per capita sales of medicines of on average 9 percent per year over the period 1987-1990.

In July 1991, a considerably more powerful policy for controlling expenditure on medicines was introduced. This took the form of a new pharmaceutical reference pricing system for people insured under the sickness funds. Under the new Drugs Remuneration System (GVS), medicines with the same therapeutic effect are grouped together and a maximum reimbursement price is calculated for all pharmaceuticals in

the same category, based on their average price in terms of the daily cost of therapy. For medicines costing more than the maximum reimbursement price, patients must pay the difference. This encourages the use of generic substitutes for branded, patented medicines when they are available. The GVS was extended to include the private sector in January 1992.

Some forecasters suggest that GVS may reduce expenditure on medicines by up to 30 percent, and that sales of generic products can be expected to increase rapidly. Others, however, point out that the availability of supplementary insurance for prescription charges may act to maintain expenditure levels and that some products currently below the GVS level may actually increase in price.[25]

The new system has been criticised by the pharmaceutical industry which fears that it could have serious adverse effects on innovative, research and development companies. In response to such criticism, the Ministry of Welfare, Public Health and Culture postponed the introduction of GVS, which had been scheduled for January 1991, and set up a committee to investigate the therapeutic grouping procedure. The pharmaceutical industry association, Nefarma, sought to block the introduction of the new system through an injunction against the government in June. However, this move failed and the scheme was introduced in July.

The latest major policy change to affect the financing arrangements governing expenditure on medicines took place this year. As part of the Dekker reforms (see Section 1.5), responsibility for reimbursement for pharmaceuticals has been transferred from the sickness funds and the private insurers to the Exceptional Medical Expenses System (AWBZ). This is part of the phased transfer of services to this fund so that eventually it will constitute the unified, basic insurance system. The changeover was not without political problems. In particular, the government had claimed that the transfer of responsibility for pharmaceuticals would result in reductions in payroll contributions and private insurance premiums for basic health insurance to offset higher patient contributions to the AWBZ fund. In fact these reductions did not materialise. After a good deal of publicity, the sickness funds and some insurance companies modified their premiums, but not by as much as the government had expected.

[25] Van de Ven (1992).

1.4 INTERSECTORAL ANALYSIS

In the government's response to the Dekker Report, four serious deficiencies in the Dutch health care system were identified:

- an uncoordinated finance structure;
- few incentives for efficient behaviour;
- unworkable government regulation governing volume and price of care; and,
- insurance market failures.

In the following section, we discuss these deficiencies in more detail. Much of this discussion relies on van de Ven (1990).

1.4.1 Uncoordinated Finance

Interrelated forms of care in the Netherlands are often financed from different sources. Thus, hospital care and care by GPs are paid for by sickness funds or private health insurers; financing of home care is based on the AWBZ; family assistance programmes are paid for by private payments as well as out of the national budget; social work is paid for by private payments and municipal budgets; financing of nursing care is based on the AWBZ; and homes for the aged are heavily subsidised from national budgets.

Separate budgetary responsibilities act as a barrier to coordinated monitoring and coordinated cost containment efforts. For instance, it is hard for the AWBZ to control nursing home spending if the fund has no direct authority or financial leverage over the physicians who make the decisions to place people in nursing homes. Thus, uncoordinated finance makes it difficult to achieve efficient substitution between different forms of care, both within the health sector and between the health care and other related social services facilities (for example, homes for the elderly and nursing homes).[26] This problem is exacerbated by the lack of incentives to providers to encourage treatment of patients in the least-cost setting.

1.4.2 Lack of Incentives for Efficiency

The Dutch health care system contains very few financial incentives encouraging efficiency among producers of care, consumers and insurers. On the contrary, the financing system is such that efficient behaviour is often financially punished, while inefficient behaviour is financially rewarded. For example:

- the hospital finance system makes inpatient admissions much more attractive than cheaper day surgery;

[26] Groenewegen (1991).

- a system of fee-for-service payments to hospital doctors sometimes encourages unnecessary and inappropriate, costly treatments;

- the capitation system under which GPs receive payment stimulates them to refer patients to hospitals rather than treating them themselves;

- the majority of consumers are close to fully insured for all of the health costs they incur regardless of their choice of provider and, therefore, have little reason to be interested in the efficiency with which resources are used when treating them;

- all sickness funds receive full reimbursement for their expenditure from the Central Sickness Fund and, therefore, face few incentives for improving efficiency;

- private insurers have stronger incentives to be cost conscious but, under the present system, the incentives tend to encourage them to insure low risk individuals rather than encouraging more efficient provision of health care.

1.4.3 Unworkable Government Regulations

Cost containment has been one of the major aims of Dutch government policy. Government regulation has been used extensively in pursuit of this goal. Examples include reductions in the number of beds, limits on hospital budgets (since 1983) and on investment in new health care facilities and even regulation of doctors' incomes. This extensive programme came under pressure in the 1980s in two respects. First, much of the legislation proved to be unworkable. Regulations often failed to recognise the complexity of health care planning and the number of parties involved, each with conflicting interests. Moreover, the regulations themselves were often vague.

Second, policies based upon tight state regulation are encountering political opposition. State intervention is increasingly being viewed as discouraging efficiency, rather than promoting it. Regulation is either ineffective, and participants in the system are able to contract around it, or it introduces unintended distortions (for example, the creation of waiting lists). A strategy more firmly based on cost consciousness and financial responsibility by those who use, provide and insure health services is considered preferable.

1.4.4 Insurance Market Failures

The partition of health insurance into a social sector, on the one hand, and a private insurance scheme on the other has given rise to a number of complexities and inefficiencies. Sickness funds generally provide insurance for people with a higher risk than those insured privately. This feature, together with the general goal of equity

between different economic groups in society, has led to the need for a complex system of compensation for adverse risk selection from the private to the social sector.

Other problems in the insurance market include the lack of competitive incentives among the sickness funds as they are essentially regional monopolies, the basic lack of choice among insurers, and transitional problems for individuals transferring from social insurance to private insurance on reaching the specified income ceiling.

1.5 ANALYSIS OF HEALTH CARE POLICY

1.5.1 Reform Proposals

The reform programme begun in the Netherlands in 1989, based upon the Dekker proposals, is far from complete, and significant political and technical obstacles remain to its full implementation. However, the general principles outlined in the Dekker report in 1987 are still accepted as the basis for reform. The reform programme contains three main features:

- there should be one basic health package for all. This will mean that existing financing sources will be channelled into one system. Sickness funds and private insurance companies will compete for enrollees;

- incentives for greater efficiency are to be offered to consumers, insurers and providers of care; and,

- there should be a shift from government regulation to managed competition as a means of encouraging the provision of cost-efficient services. Government responsibilities, however, will still be exercised to ensure an acceptable quality of care, adequate financial and geographical accessibility for all patients, a local supply of services in relation to the needs of the population, and solidarity between social groups.

The system will work as follows:

- individuals pay an income related premium into a central fund (an expanded AWBZ);
- individuals enrol with an insurer of their choice for basic cover. The insurer must accept all comers;
- individuals pay a fixed premium, unrelated to risk, to their chosen insurer. The premium may vary from insurer to insurer, in part due to their efficiency;
- the insurer receives a risk-adjusted capitation payment from the central fund for each enrollee;
- insurers contract with providers for delivery of health care;
- individuals can take out supplementary insurance for services not in the basic package.

The relationship between the main participants in the health care system can be described as a triangular structure which highlights three sets of bilateral relationships, namely:

- the relationship between consumers and insurers;
- the relationship between insurers and providers; and,
- the relationship between providers and consumers.

1.5.1.1 *Consumers and Insurers*

The compulsory basic package will cover GP services, hospital treatment and specialist fees, as well as nursing homes, family care and certain forms of home health care. The basic insurance scheme will be financed approximately 85 percent from an income-related premium and 15 percent a fixed premium (see Chart 1.3). The income related premium will be collected by the tax authority and paid into a central fund. Insurers will receive risk-adjusted capitation payments from the fund for the consumers who insure with them, adjusted for the main determinants of risk (eg. age).

A key function of the central fund is to combine the goals of equity and efficiency. Income-related payments from contributors permit any desired degree of cross-subsidisation between high and low income groups, between healthy and unhealthy people and between young and old people. At the same time, risk-adjusted capitation payments to insurers are an attempt to neutralise the insurer's incentives for preferred risk selection (see Section 1.5.2). Competition for insurees can then focus on providing health insurance and health care to consumers as efficiently as possible.

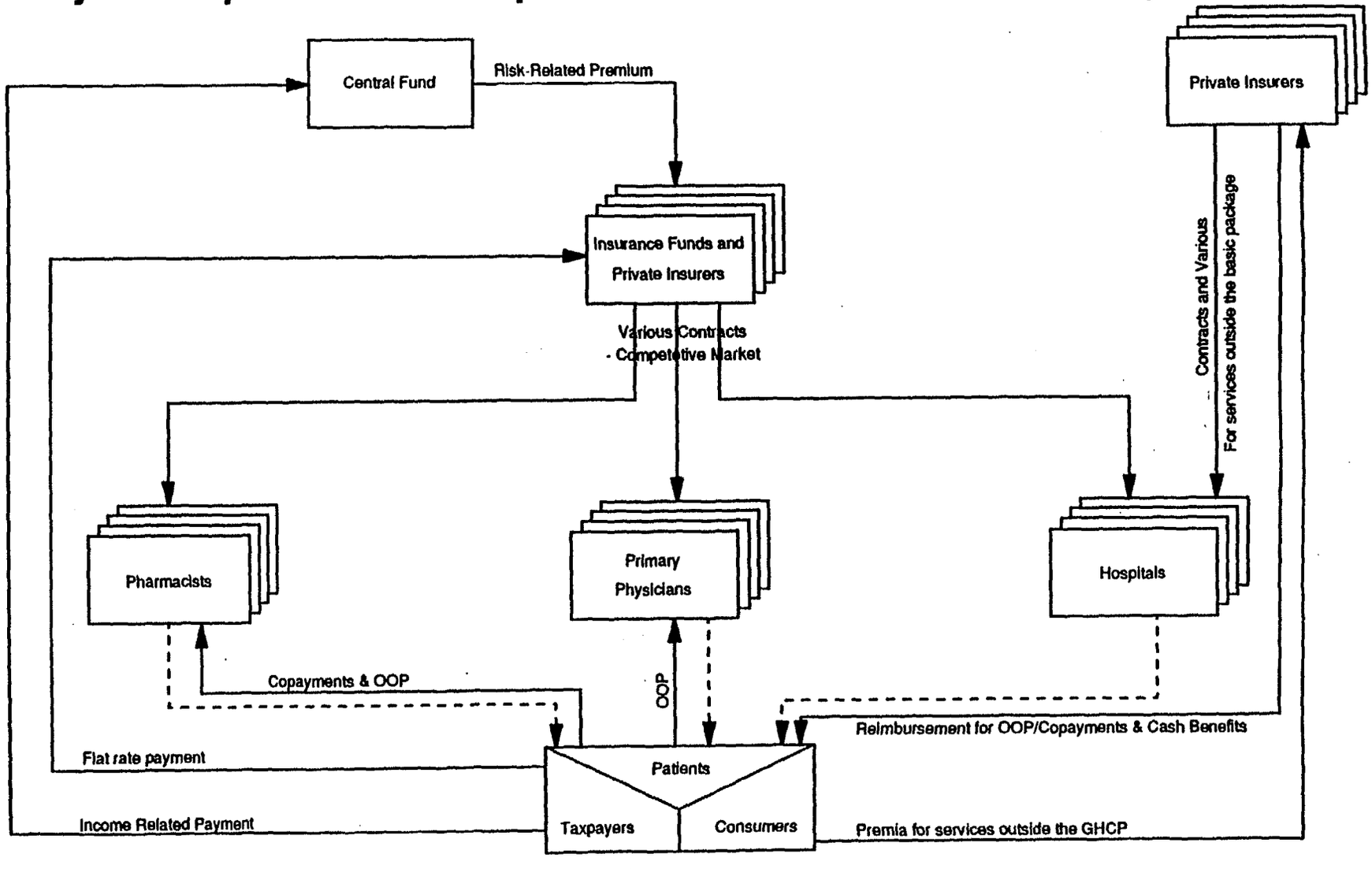
The fixed premiums paid directly by consumers to insurers may vary from insurer to insurer, but will not depend on the risk characteristics of individuals. Variations in fixed premium levels between insurers, based upon different levels of management efficiency, are expected to be one of the main areas of competition between insurers. Consumers can save by choosing an efficient insurer who keeps premiums down or by choosing an insurance package that covers the basic services but may or may not include copayments or restrictions on choice of provider (as found in the US HMO system).

In addition, consumers will be free to take out supplementary insurance to cover health care and social service costs not covered by basic insurance. According to the 1988 government proposals, this will include such services as some of the costs of medicines, physiotherapy and dental treatment for insured people above the age of 18. There has, however, been a continuing discussion about what exactly should be excluded from the basic benefits package and this may well change. Supplementary insurance will be financed entirely by fixed premiums set by insurers.

Since premiums paid to insurers out of the Central Fund will be risk-adjusted, insurers will be required to offer open enrolment; consumers cannot be refused insurance on the grounds of high risk. Insurers will not be able to price discriminate between consumers in terms of the fixed premiums they charge for either basic or supplementary insurance, although premiums are expected to vary between insurers.

Eventually, it is expected that the distinction between sickness funds and private health insurers will disappear as they both compete for customers on common terms.

Chart 1.3
Key Participants in the Proposed Netherlands Health Care System



1.5.1.2 *Insurers and Providers*

Under the new system, insurers will negotiate contracts with providers. Negotiations between them are expected to cover the volume, quality and price of care. Moreover, in contrast to the existing system, insurers will be able to contract selectively; that is, they may choose between providers on grounds of efficiency rather than having to accept bills from any provider who offers services. Consumers must explicitly accept such restrictions when they sign up with a specific insurer and a specific plan offered by that insurer. Insurers will presumably be free to offer plans without restrictions if consumers favour that type of insurance.

Competition between insurers for consumers is expected to act as a stimulus to keep nominal premiums as low as possible, and this is expected to improve cost-consciousness in their contracts with providers. Any threats that this might offer to the quality of care are intended to be allayed by clear specification of the services that consumers will be expected to receive. Consumers will also discipline quality through their choice of insurer. In some cases, it will be necessary for the government to lay down minimum standards. For instance, it is proposed to amend the Hospitals' Facilities Act to provide for the monitoring of large residential institutions.

Under the previous planned health care system, various regulations were used to create a cohesive and efficient network of facilities in each region, in keeping with the needs of their local populations. Henceforth, however, the government sees regional development as being primarily the responsibility of providers and insurers. Providers will be put at risk for their revenues. If they are successful in running efficient facilities, they can buy the necessary plant and equipment out of the revenues they receive.

Similarly, agreements on prices and budgets will be an essential part of the contracting process between insurers and providers. Negotiations will take place at the local level. It will no longer be appropriate for tariffs or hospital budgets to be set centrally. In some cases, however, cartels may form on either the insurer or provider side. In these circumstances, the government has made it clear that intervention through antitrust enforcement may be necessary either to stimulate or regulate the market. However, this will be very much a policy of last resort.

1.5.1.3 *Providers and Consumers*

Consumers will have choice between insurers and different types of policies. While choice is based in part on the level of the flat premium and the type of plan being offered, the quality of care offered by providers with whom individual insurers have contracts can be expected to be an important consideration for consumers. Dissatisfied consumers are expected to vote with their feet if quality standards with a particular insurer and/or provider are not met. The ability of consumers to express preferences provides the appropriate signals for the allocation of resources in the health care

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market, and provides an important check on quality. Beyond this, however, it may be necessary for the government to support quality assurance through the promotion of accreditation initiatives or other forms of quality certification.

1.5.2 Consequences of the Reforms

Van de Ven (1990) points out that the reform package will have far reaching consequences for insurers, providers and consumers.

The role of insurers - both sickness funds and private health insurers - will change dramatically. Instead of acting as administrative payers or pure indemnity insurance companies, they will need to become cost-conscious purchasers of care. Sickness funds will receive a fixed but risk-adjusted budget allocation with which to purchase care. Moreover, they will lose their regional monopoly and will have to compete with other insurers. They will be able to contract selectively with providers. Private insurers will be confronted with pro-competitive regulation such as open enrolment. Preferred risk selection should become less of a problem as a result of risk adjusted capitation payments from the central fund.

Supply side competition can be expected to develop as providers compete for service contracts on the basis of price and quality. This should increase productive efficiency in the use of resources by providers. One manifestation of this incentive for greater efficiency is likely to be further pressure to reduce excess capacity in the supply of hospital beds, presently estimated to be about 25 percent. Doctors too will feel the pressures of competition. Fixed fees will no longer be guaranteed and they will no longer be able to expect new contracts with insurers to be issued automatically.

Consumers will be permitted to choose the insurer, the insurance scheme, and, implicitly, the provider which most closely satisfies their needs and preferences. The fact that insurers and providers will be competing for enrollees means that the appropriate signals for the allocation of health care resources will be forthcoming. Open enrolment will protect consumers from the effects of risk selection to the extent that the risk adjustment is imperfect.

Van de Ven (1991) notes several problems that are likely to be involved in the transition from a centrally planned health care system to one based more upon market principles.

- There is a problem of consumers' lack of information. In particular, there is a serious shortage of information on quality. Without good information on the quality of care offered, consumers will not be able to make sound decisions between competing insurers and providers. A high priority should be attached to the task of disseminating understandable information to consumers. Ways of doing this include the establishment of independent institutes of certification for providers, encouraging providers and insurers to disseminate information and/or establishing independent organisations which would publish relevant

data. As competition among insurers evolves, it is expected that the competitive process will produce substantial information as a method of convincing consumers to register with one insurer rather than another.

- Prices within the Dutch health care system are presently determined through negotiations between provider and insurer organisations and by government regulation. As such, prices are only poorly related to costs and as yet cannot be relied upon to provide the right signals for encouraging efficient resource allocation. Far better cost information needs to be generated in order to set prices in relation to actual resource costs. Competition is expected to stimulate the production of this information since providers must know their costs of managing patients if they are to bid for contracts to provide medical services.

- There are presently a number of price cartels (between, for example, physicians, dentists and pharmacists) and regional cartels (between, for example, sickness funds and GPs) that could inhibit the workings of the price system. As such, an effective antitrust policy is central to the creation and maintenance of a competitive health care system.[27]

- Management skills are seriously underdeveloped in the Netherlands. Under the old style administrative system, managers acted more like bureaucrats and were given little discretion. To be able to take advantage of the opportunities offered by a market system, they will be required to take responsibility for revenue raising, managing within budgets and managing their staff in ways that they have not been called upon to do before. Managing clinicians, who have traditionally enjoyed a high degree of professional autonomy, will be a major part of this task. Since the clinicians rely on the hospital, co-operation in bidding for insurance contracts and sharing risk with the hospital is expected.

Another aspect of the Dutch reforms that has attracted the attention of health economists is the potential for preferred risk selection, or 'cream skimming', that could arise as the result of an imperfectly risk-adjusted capitation system.[28] Cream skimming refers to the selection of good risks by insurers (those for whom the capitation payment is above the expected costs of their care) and the rejection of poor risks. It arises because of information asymmetry between insurers and those determining the capitation payments. While it is efficient for insurers to consider the risks they take on, preferred risk selection has a number of adverse consequences. Most notably, it leads to restrictions on access to care for those with poor health.

Methods which they might potentially use to carry this out include designing benefits packages to deter poor risks, using selective advertising and mailing, using agents that

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27 See Schut et al. (1991) for a discussion of this issue.

28 van Vliet and van de Ven (1992).

are familiar with family health records and even offering 'golden handshakes' to poor risks if they disenrol.

Research evidence suggests that the potential profits from preferred risk selection are large if capitation payments are based on standard risk-adjustment factors such as age, gender and location. It appears that the maximum amount of the total variance in acute health expenditure per individual which is explainable is between 15-20 percent, while the standard adjustors are only likely to explain about two percent. Prior utilisation of health care services by individuals seems to be the best predictor of future expenditure, explaining up to two-thirds of the explainable variance. Thus, with the prospect of large profits and access to predictive information that is not included in the capitation formula, insurers have both a strong incentive and the ability to engage in preferred risk selection.

Van Vliet and van de Ven (1992) suggest that the Dutch government has two policy instruments with which it could reduce the threat of preferred risk selection; namely, by refining the capitation formula to include more of the risk adjustment factors known by insurance companies and by encouraging pro-competition policies.

Their research - based upon a panel of 35,000 people - shows that global parameters, such as age, gender and location, can explain about one-fifth of the explainable variance in annual health care expenditure. If the individual's prior year's costs are added as an explanatory variable, about three-fifths of the explainable variance in costs can be explained. Further analysis, using the Dutch Health Interview Survey (with a sample size of approximately 20,000), indicates that the addition of three health status indicators and several background characteristics increases the proportion of variance explained to three-quarters of its maximum level. Taken together, this evidence suggests that, in the short term, information on prior expenditure should be included in the capitation formula. In the longer term, as information becomes available, indicators on chronic health status based upon previous hospitalisations should also be added, especially since this information would be available to insurers.[29]

Alternatively, they argue that pro-competition policies could be used to overcome preferred risk selection. The incentive to select the lowest risk enrollees would be greatly reduced, for example, if insurers were able to vary the size of the flat rate premium between individuals on the basis of perceived risk. They claim that this would probably only produce a small variation in total premium payments but that this might be sufficient to deter preferred risk selection. Socially unacceptable premium differences could be avoided by setting upper and lower bounds on the flat rate premium. Moreover, a subsidy could also be provided to low income groups if this was deemed necessary. Van Vliet and van de Ven point out that risk sharing between the central fund and the insurers would also reduce the incentive to risk select.

[29] van Vliet and van de Ven (1992).

Overall, van Vliet and van de Ven believe that preferred risk selection is potentially a serious problem, but there are several strategies that might be used to reduce its negative effects. At the moment they have reservations about whether the government can implement the necessary measures, because of their lack of patient-specific information on prior utilisation.

1.5.3 Preliminary View of the Reform Programme

The Dutch reform proposals represent a coherent and consistent attempt to meet the multiple objectives of their health care system. The unified basic insurance package is designed to ensure equitable access to health care for all the population. It embodies the important concept of social solidarity in which cross-subsidies flow from higher income groups, the young and the healthy to lower income groups, the elderly and the sick.

Within this environment, efficiency gains are being sought through competition between insurers and between providers. It is intended, however, that competition will be managed, or regulated, to ensure that quality, access and other dimensions of care, which may be threatened in a totally free market, are maintained. Still, consumers will have choices and will be able to register their preferences for the style and level of care they most prefer. This encourages an efficient allocation of resources in the health care system.

There are many technical aspects of the reforms which need to be addressed if they are to work as hoped. It appears that management skills are seriously underdeveloped within provider organisations. In particular, clinicians have rarely been involved in the management process. Effective integration of clinicians into management decision making is likely to be a prerequisite of greater efficiency within hospitals and other providers. Further, the development of a satisfactory risk-adjusted formula for capitation payments will be necessary to avoid preferred risk selection.

More generally, however, the political context within which these changes take place is likely to be crucial and can be expected to govern their extent and the pace at which they proceed. At the outset, the Dekker proposals gained bi-partisan support, in contrast with many past reform proposals, because they combined features that were attractive to both of the main political constituencies. The Right was attracted by greater competition, while universal basic insurance appealed to the Left. Subsequently, however, new divisions have appeared. It has become clear that income-related premiums involve a redistribution of income away from higher income groups because, under private insurance arrangements, their payments were not income-related. Some private insurers have expressed concerns about the bureaucracy with which they will have to deal in order to receive capitation payments. Continuing debate on these and other political issues has slowed the implementation of the reforms. Many informed observers now doubt whether they will be implemented to any significant extent for at least another 10 years.

GERMANY

Nera Report

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Financing Health Care with
Particular Reference to Medicines

Volume 5

THE HEALTH CARE SYSTEM IN GERMANY

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CHAPTER 1
PROFILE OF THE HEALTH CARE SYSTEM

1.1 SUMMARY

- Structure

The health care system of the Federal Republic of Germany is based on a comprehensive statutory health insurance scheme. Health insurance with an insurance (or sickness) fund is mandatory for the majority of the population. There are more than 1,000 such funds. In general, all individuals are at present eligible to join the local fund whose boundaries include their place of work. A segment of the population has choice of becoming a member of one or several other funds subject to meeting the membership qualifications of those funds. According to legislation passed in December 1992, these membership restrictions will be lifted in the near future.

- Aggregate Level of Expenditure

Sickness funds and primary care physicians, through their regional and national organisations, negotiate the level of global budgets from which fee-for-service payments are made. Flexible hospital budgets, based largely on *per diem* rates, are usually determined in negotiations between hospitals and sickness funds at the local level. The federal government can set national guidelines for the annual round of negotiations through the so-called 'Concerted Action'. This is a national forum which brings together the key participants of the health care sector.

- Incentives

Office-Based Physicians: fee-for-service reimbursement provides doctors with a financial incentive to treat as many patients as possible, and to expand the volume of services. Policies designed to cap overall expenditure of physicians lead to strong competition amongst physicians that often takes the form of volume increases.

Hospitals: prior to legislation enacted in 1992, hospitals were reimbursed through flexible budgets, based largely on *per diem* rates. Hence hospitals had an incentive to treat all patients as long as capacity was available, and to provide treatment for longer than may have been necessary. According to the new legislation *per diem* rates will be replaced by prospective payments made on a cost-per-case basis. Furthermore, flexible budgets have been abolished.

- Issues

A guaranteed health care package, to which all members of the statutory sickness funds are entitled, is defined in the health care legislation. Enrolment with sickness funds is open but subject to membership restrictions of individual funds. The fact that some people have a choice of which fund they wish to join means that there is scope for risk-selection. As a result, there is premium differentiation across funds. The 'hidden competition' between funds takes other forms as well, such as generous interpretations of health care service entitlements.

Office-based physicians have an incentive to expand service volume and thus to over-provide treatments. Hospitals have had little incentive to use resources efficiently, since in general they have had their expected costs reimbursed by insurance funds. There still is a lack of integration between primary and secondary care; this lack of coordination leads to some duplication of work and hence costs.

- Medicines

Pricing of medicines is free from direct control at manufacturers' level. However, 'reference prices' were introduced in 1989. These represent the levels at which sickness funds reimburse prescription medicines. Patients are required to pay the difference between price and reimbursement level. As a consequence manufacturers' prices for many medicines have converged towards reference prices. The structure of copayments for medicines has been altered several times. The 1993 Health Care Act introduced a number of changes to the pricing and reimbursement of medicines. These include a price freeze and price roll-back on non-reference priced medicines during 1993/94 and copayments on all prescription medicines. A global pharmaceuticals budget was introduced for 1993; this will be replaced by regional budgets and prescription limits in 1994.

- Reforms

Several health care cost containment acts have been passed in the last fifteen years, to restrain the costs of the health care system. The 1993 Health Care Act introduces some far-reaching structural and organisational reforms to the health care system over the coming years. The Act also proposes short-term cost containment measures. These measures take the form of revenue-linked expenditure ceilings or capped budgets for specific health care services.

- Political Environment

The German health care system is embedded in the so-called 'social market economy' which constitutes the framework for German social and economic policy making. Social market economy principles which affect the health care system are those of self-governance, social partnership, and social solidarity. It is difficult to imagine circumstances under which attempts to abandon these principles would be politically acceptable.

1.2 STRUCTURE OF THE HEALTH CARE SYSTEM

1.2.1 The Health Care System in Context

The Federal Republic of Germany[1] has a comprehensive health care system which covers everything except long-term or permanent care. It is based on a compulsory insurance scheme. The insurance scheme is highly decentralised and comprises more than 1,000 *insurance funds* (or *sickness funds*; the terms are used synonymously throughout this report). Approximately 90 percent of the population are insured with one of the compulsory insurance funds. (Four percent have additional insurance with private insurers). Eight percent of the population are fully covered by private insurance. The remaining 2 percent are mainly civil servants for whom the Government administers health care.

Health insurance is one of the four branches of social insurance in Germany. The other three branches are work-related accident insurance (paid exclusively by the employers), pensions insurance and unemployment insurance.

Entitlements of the health system are generous by international standards and several health care services are free at the point of delivery. Benefits in kind include primary care, in-patient hospital care, dental care and even rehabilitation and preventative care stays in health resorts (*Kuren*), but not long-term care; benefits in cash include sickness payments, and burial allowances.

At the national level the Federal Government passes health care act amendments which apply nationwide. The health care legislation lists the health care benefits to which all Germans are entitled and specifies the regulatory regime which governs the health care system. Through the so-called 'Concerted Action' (*Konzertierte Aktion*), a national forum which brings together representatives of insurance funds, physicians and other organisations, the Federal Government sets national priorities for the annual round of negotiations between health care providers and purchasers.

Several amendments to the existing health care legislation, so-called cost containment acts, have been passed in the last fifteen years. The latest reforms came into effect in January 1993. Throughout this report this act will be referred to as the '1993 Health Care Act' (*Gesundheits-Strukturgesetz*).

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[1] This chapter describes the health care system in the western *Länder* of the Federal Republic of Germany. At present the former German Democratic Republic is in the process of adopting the laws and regulations of western Germany. This includes all matters relating to health care. This means that the analysis of the health care system described in this chapter applies to both western Germany and - allowing for a transitional phase - eastern Germany. The data sets, however, refer exclusively to West Germany. Annex 1 briefly describes the process of integrating eastern German health care into the western German system.

The responsibility for providing ambulatory health care rests mainly with office-based (primary) physicians (*Sicherstellungsauftrag*); this responsibility may be transferred to sickness funds if physicians fail to fulfil this obligation.[2] Regulation and supervision of the provision of health care, however, is largely the responsibility of the eleven (since 1990: sixteen) states (*Länder*) which constitute the Federal Republic of Germany. They are also largely responsible for financing hospitals' capital expenditure and for the supervision of the health care system. The ministries in charge of this duty are the *Länder* Ministries of Labour and Social Affairs.[3] Regulation of the financing side of the health care system is largely a matter for the federal authorities. Thus health care in Germany is regulated and supervised by both federal and *Länder* ministries (as well as other organisations such as the Federal Insurance Office).

After the last federal elections in December 1990, the Government reorganised the Ministry of Youth, Family and Health as three separate ministries. In this process, the Federal Ministry of Health was created.[4] At the same time, the responsibility for social health insurance, which previously lay with the Federal Ministry of Labour and Social Affairs, was transferred to the newly created Ministry of Health.

1.2.2 General Features of the Finance System

The foundations of a statutory health insurance system were laid by Chancellor Bismarck in 1883, although several health insurance schemes already existed at that time.[5] The financing side of the German health care system is characterised by self-governing statutory insurance funds. In 1911, 18 percent of the population was insured; by 1990 this figure had risen to approximately 90 percent.

Insurance funds are organised on a local, company, or national basis. Sickness funds reimburse health care providers for a broad range of services. An exception is long-term residential care which is not covered. Sickness funds are largely financed through a proportional[6] payroll tax which is levied on income earned in regular employment. Both employer and employee contribute equally to health insurance payments. Other

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2 This means that in case of a collective boycott of physicians the responsibility for providing health care is passed on to sickness funds. In order to fulfil this obligation sickness funds may contract directly with individual doctors, or they may establish their own provider organisations. Physicians who have participated in a boycott may re-apply for accreditation with a sickness fund after a period of six years.

3 The *Länder* Ministries of Labour and Social Affairs have different names in different *Länder*. Some specifically mention 'health' in their title, while others do not. The exception is Bavaria where health care is largely supervised by the *Land* Interior Ministry.

4 The other two ministries created in the process are the Ministry for the Family and the Elderly, and the Ministry for Women and Youth.

5 Compulsory accident insurance followed in 1884. Pension funds were established in 1889.

6 Contributions only start after a minimum threshold, so they are not strictly proportional.

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sources of sickness funds' revenues include transfers by pension funds, local unemployment offices and welfare organisations.

Sickness funds are required to accept all persons who qualify for membership. In particular, the local funds must accept all comers whose place of *work* falls within their geographical boundaries (the 1993 Health Care Act extends the membership option to place of *residence*). They must also set premiums which do not discriminate on grounds of age, sex or risk factors. Furthermore, premiums are set and reviewed regularly to ensure that neither excessive reserves nor deficits accumulate. Thus there is general risk-sharing (solidarity) across all members of a particular sickness fund and funds operate on a pay-as-you go basis.

Each individual's contribution to a sickness fund is linked to income. The contribution is deducted directly from the individual's pay-cheque and transferred to the individual's sickness fund. Sickness funds also act as first recipient of the individual's pension and unemployment contributions. These payments are then transferred to the individual's pension and unemployment fund.

People above a certain income level (in 1992: DM 61,200 or $24,000 1990[7]) may choose to become voluntary members of the social insurance system, or to opt out of the system and seek private health care insurance instead. Such a decision is usually irreversible. On the other hand, private health insurance companies may link their premiums to the perceived risk of the individual. However, in practice, most private health insurers charge community-rated premiums that are based on gender and age only.

The 1993 Health Care Act has relaxed membership restrictions of sickness funds. It is envisaged that a large part of the population may eventually choose the sickness fund they wish to join. The new system will be introduced in 1997 (see Section 1.3.3).

1.2.3 General Features of the Delivery System

Patients have the right to seek treatment from any office-based and sickness fund accredited physician. Physicians act as gatekeepers to hospital services. Within limits, physicians and patients also have free choice with respect to the hospital to which patients are referred.

In 1990 there were 195,254 doctors in (western) Germany. This amounts to 3.1 doctors per thousand population, compared with an average of 2.3 per thousand over our

[7] Throughout this Report values are given in local currency and in 1990 US$. Conversions are made at 1990 Purchasing Power Parities. Further, figures in 1990 US$ are effectively equivalent to 1990 ECUs, for while the current $/ECU exchange rate is 1 ECU = $1.382 (Financial Times, 6 August 1992), Purchasing Power Parity suggests a rate of 1 ECU = $1.021 in 1990. Sources: OECD 1991; OECD 1992a; OECD 1992b.

study countries.[8] Of these 75,251 were office-based physicians; 96,203 were clinicians; 8,356 were in public office; and 15,444 were in other forms of employment.[9] The number of doctors has risen steadily during recent decades.

At the beginning of 1990 there were 3,046 hospitals in (western) Germany with 670,000 beds (10.8 per thousand population, compared with an average of 9.1 per thousand over our study countries). Most hospitals are owned by public authorities or private non-profit organisations; some are in private ownership. Less than 10 percent of hospitals own more than 30 percent of all beds. The number of acute hospitals has been decreasing, while the number of hospitals for the chronically ill has increased slightly in recent years. The number of hospital beds rose from approximately 580,000 (in 1960) to 760,000 (in 1974), and has since decreased to 670,000 (in 1989).

1.2.4 Inputs and Outputs of the System

In 1989 total health care expenditure was DM 277 billion ($119 bn 1990). In comparison to 1970 when health care expenditure stood at DM 71 billion ($62.9 bn 1990), this is an increase of approximately 90 percent in real terms.

Of the DM 277 billion total health care expenditure in 1989, DM 50 billion (18 percent) was spent on ambulatory (primary) care, DM 60 billion (22 percent) on in-patient care, DM 37 billion (13 percent) on pharmaceutical and medical aids, DM 77 billion (28 percent) on rehabilitation and benefits in cash, and DM 18 billion (6 percent) on preventative and maternity care. The remaining DM 35 billion (13 percent) was spent on dentures, education and research.

These data are shown in Chart 1.1, along with the breakdown of total expenditure on health care by different payers. Sickness funds account for approximately 50 percent of overall health care expenditure. The other half comes from pension funds, accident insurance, employers, government expenditure, private health insurers and patient copayments. Pension funds are responsible for the finance of rehabilitation care for people who are in employment or are potentially able to work. Statutory accident insurance is usually responsible for financing all acute or non-acute treatments as a result of injuries inflicted on people during work. (The accident insurance, financed by employers, generally reimburses the sickness funds which, in the first instance, reimburse providers). Contributions by employers in Chart 1.1 mainly relate to benefits in cash during absence of work because of illness. The federal and *Länder* governments are responsible for public health and capital investment programmes, e.g. hospital facilities.

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8 The countries in our study are: Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Spain, Sweden, the UK, and the USA.

9 Source: *Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen* (1992).

Expenditure by statutory insurance funds has increased steadily in recent years. In 1970 it was DM 24 billion ($21 bn 1990), in 1980 it was DM 86 billion ($47 bn 1990), and by 1990 it had risen to DM 134 billion[10] ($56 bn 1990). Insurance funds pay the majority of health care costs related to primary care, hospital care and medicines.

At the end of 1989 the size of the population of West Germany was around 62 million. That of East Germany was 16.4 million. From 1970 to 1988, the size of the population in West Germany has changed very little.[11]

Life expectancy at birth has steadily increased and stands now at 72 years for males and 79 years for females, slightly below the averages for our study countries which are 73 and 80 respectively. On other measures of health status, Germany is close to the average for our study countries with an infant mortality of 7.5 per thousand (average 7.6), and 'potential life years lost'[12] of 29 per thousand for females and 52 per thousand for males (average 30 and 52). By international standards, Germany does well on perinatal mortality (6.4 per thousand, average 8.6).

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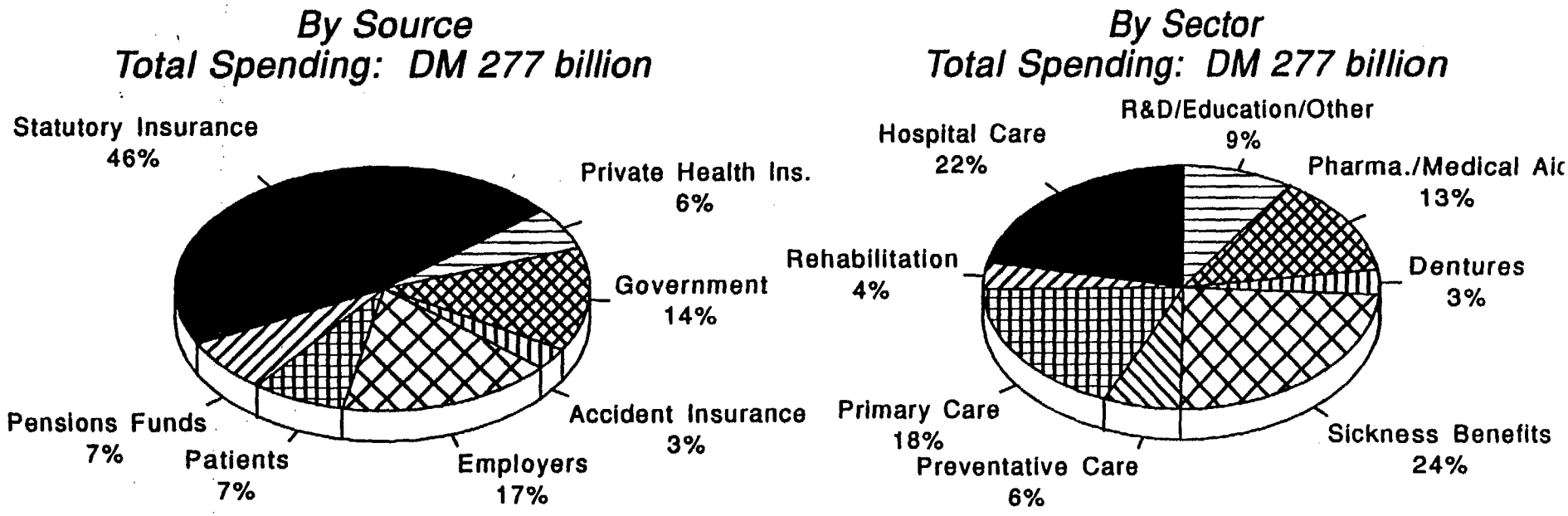
10 Source: *Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen* (1992), Table T465.

11 Source: OECD Health Data (1991).

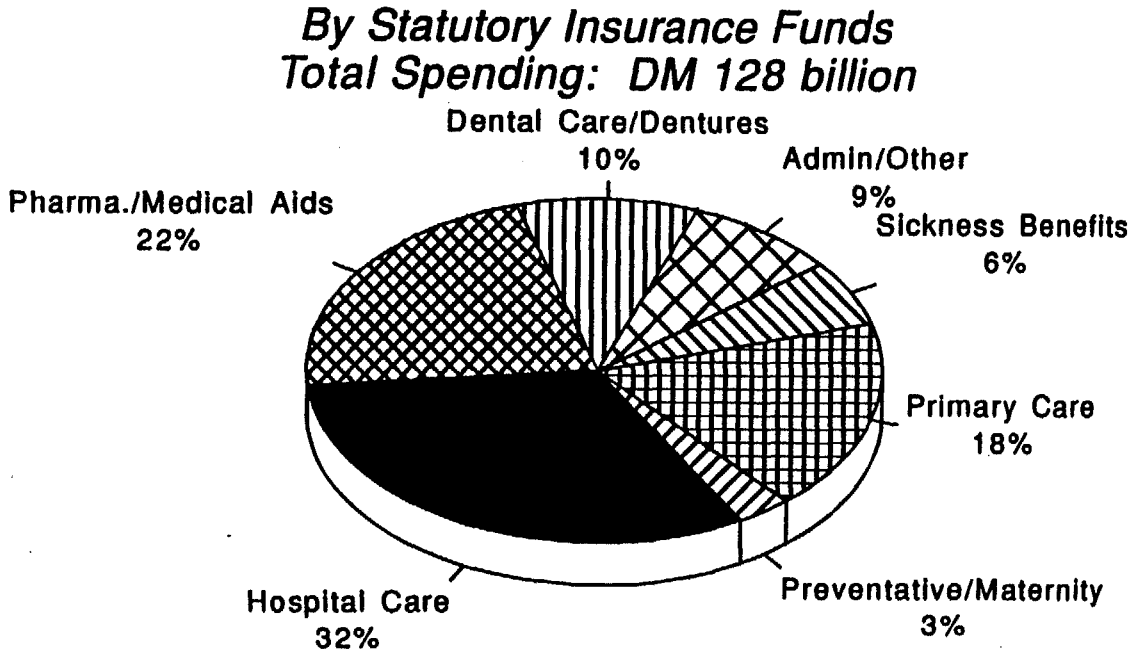
12 Potential Life Years Lost: this is a WHO estimate of years of life to deaths which could have been prevented by the use of currently available technology, improved public health, or less risky behaviour.

Chart 1.1 A
Expenditure on Health Care in Germany, 1989



Source: Daten des Gesundheitswesens, 1991, p.174, 258, 259

Chart 1.1 B
Expenditure on Health Care in Germany, 1989



Source: Daten des Gesundheitswesens, 1991, p.174, 258, 259

1.3 ANALYSIS OF INDIVIDUAL SECTORS

1.3.1 Key Participants in the Health Care System

Chart 1.2 provides an overview of the key participants of the German health care system, and the flow of funding and delivery of services in the system. Other relationships which are not linked to the funding and delivery of services, such as membership associations, are also indicated in the chart.

In Section 1.3 we describe the role of the key participants of the German health care system. The key players are:

- The patients, who are also members of insurance funds;
- the statutory insurance funds, as well as their *Land* and federal associations;
- the primary sector (i.e. office-based physicians and specialists), as well as their *Land* and federal associations;
- hospital clinicians;
- the hospitals, as well as their *Land* and federal associations;
- the pharmaceutical sector;
- the Ministries of Labour and Social Affairs in the *Länder*; and the Ministry of Health of the Federal Government.

In addition, there are numerous scientific and medical research-based institutions in Germany, as well as professional associations and self help groups such as the German Multiple Sclerosis Society or the German Aids Help. There are no patient rights groups with significant influence in Germany.

In the remainder of this chapter *office-based physicians* (*Kassenärzte*) will sometimes be identified as 'primary physicians', as opposed to *hospital-based physicians* for which the term 'clinicians' is used.

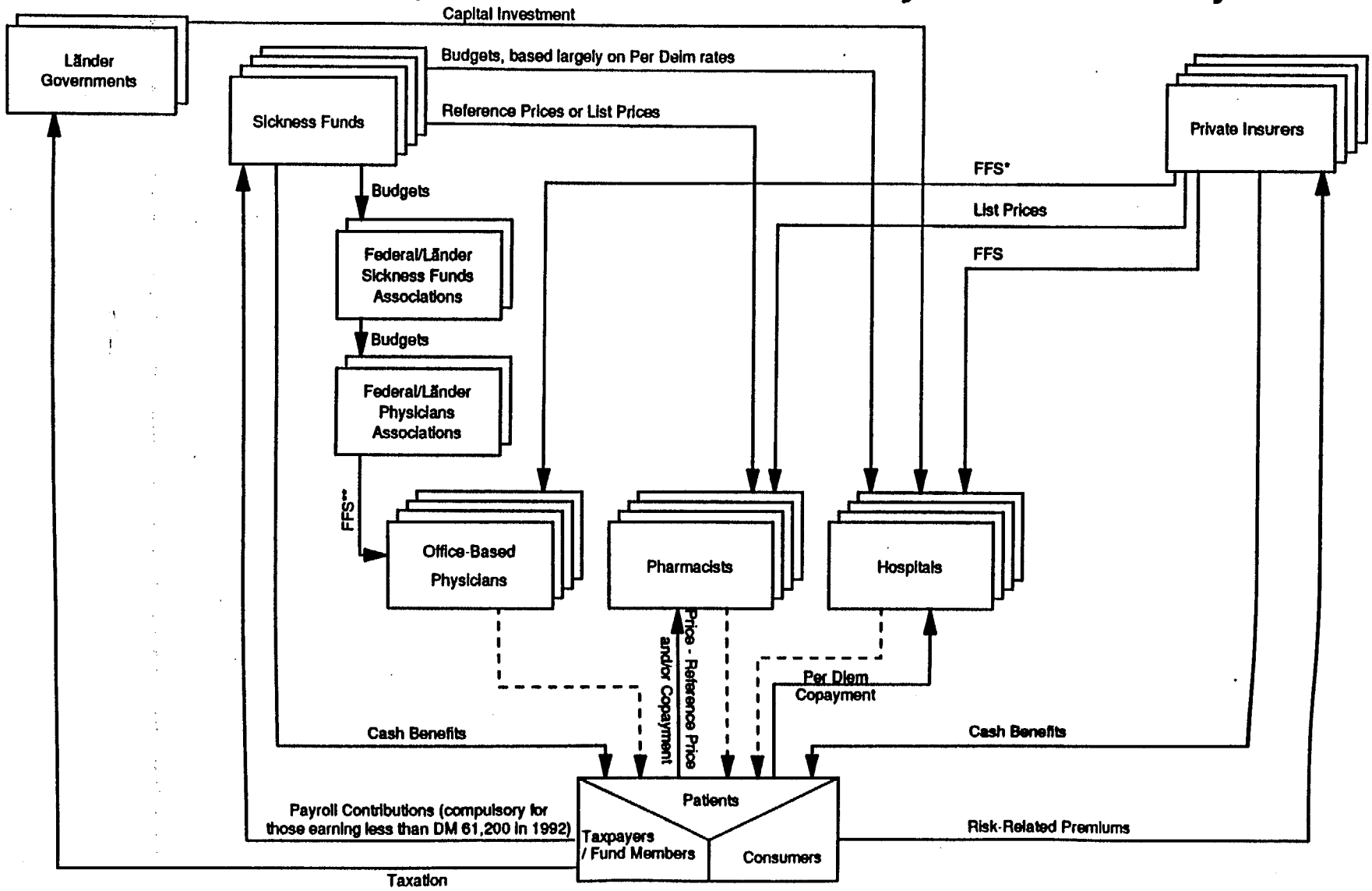
1.3.2 Patients

1.3.2.1 Attitudes Towards the Health Care System

Germany's statutory health insurance system is based on the principle of solidarity. That principle states that citizens should receive health care benefits according to their needs and should pay according to their ability. Consequently, the general view that appears to prevail in Germany is that health care should largely be free at the point of delivery and should be comprehensive.

Legislation enacted over the past decades has seen a gradual extension of health care benefits. Today they even include rehabilitation and preventative care in health care resorts. It is generally felt that the entitlement mentality of the population coupled with the fact that reimbursement methods for health care services are largely based on

Chart 1.2
Key Participants in the Health Care System in Germany



Financial Flows

Service Flows

* Private insurers generally pay higher prices than sickness funds, but follow the same relative fee schedules

** The value of a "point" is defined at the Federal level as (Total Budget / Total Points Billed)

a fee-for-service regime have led to a generous provision of services and facilities to deliver these services. Queues for health care services are virtually unheard of.

However, there is a continuing debate on health care reform, and health care policy is an important political topic in Germany. In surveys conducted periodically by the research organisation *Infas*, health care reform policies were considered to be an 'important topic' by 50 percent of all Germans in 1989.[13] In 1987, the figure was 24 percent. When asked to compare the importance of health care reform with other political topics, health care reform came fourth in the ranking order (with 50 percent) in the survey in 1989, after 'unemployment' (62 percent), 'maintaining social security' (61 percent) and 'environmental protection' (59 percent). But it came before 'disarmament and peace' (37 percent), 'pensions' (33 percent) and 'economic growth' (33 percent). Two years earlier, health care reform ranked only eighth.

The same survey suggests that Germans in general are satisfied with the health care provision in their country. In 1988, 29 percent of interviewees were said to be 'very satisfied' with the health care service, while 61 percent said that they were 'satisfied'. However, 45 percent of those being asked thought that the Health Care Cost Containment Act of 1989 would make the quality of health care worse. Only 3 percent thought that it would get better, while 45 percent thought that quality would not change.[14]

1.3.2.2 Roles and Objectives of the Individual Patient/Insuree

Besides having their health restored, patients have few objectives other than receiving prompt treatment at no or little cost whenever the need arises. This includes free choice of physician, and, to a lesser extent, free choice of hospital (both subject to transport costs).

In the role as payer, the insuree's objective is to keep the annual increase of their insurance fund contributions low, while receiving high quality health care services. There is little evidence that Germans think of the health care system to be seriously underfunded. There is, however, no direct link between insurance contributions and benefits. As a result, patients demonstrate little cost-consciousness.

According to an international survey, patients in Germany appear to trust their doctor's medical judgement. There is little evidence that patients question a doctor's diagnosis or choice of treatment. Physicians are self-employed professionals and enjoy a high status in German society. The same applies to clinicians, although they are generally employed by hospitals. Trust in doctors' behaviour is also reinforced by the fact that relatively few cases of malpractice or incorrect diagnosis are dealt with by courts.

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13 Infas: *Aktuell Politogramm der Woche* 50 (1988) and 3 (1989).

14 *Ibid.*

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Instead, malpractice cases are usually settled by mediation involving physicians' organisations.

1.3.2.3 Objectives of the Insured Population

The German health care system is embedded in the German social and economic system, the so-called 'social market economy' (*Soziale Marktwirtschaft*). The values underlying the health care system can be characterised by several basic principles, which in turn stem from the values relating to a social market economy. The most relevant of these are the principles of self-governance, social partnership, and social solidarity. Self-governance means that purchasers and providers of health care should operate as self-managing private organisations (under public law) with as little interference from the government as possible. Social partnership rests on the assumption that both employers and employees should share the burden of financing health care. Social solidarity means that the economically stronger members of society should support the weaker members to ensure equality in the provision of health care. Specifically, this means that:

- the younger and healthier subsidise the older and less healthy;
- those with higher incomes subsidise those with lower incomes;
- those who are single and childless subsidise families and those with children; and,
- those who are employed subsidise those who are unemployed.

It is difficult to imagine circumstances under which it would be politically acceptable to abandon these general principles as part of health care reform policies.

1.3.3 Payers

1.3.3.1 Structure of the Insurance Sector

In 1990, approximately 90 percent of the population of (western) Germany, 55 million people, belonged to a statutory insurance fund (*Krankenkasse*). In 1991, 1,135 such insurance funds existed, a number that had gradually decreased from approximately 22,000 in 1911. About 8 percent of the population is covered exclusively by private health insurance schemes (although many people have supplementary private insurance). Approximately 2 percent are covered by special arrangements for civil servants (e.g. police and military forces). The government administers health care coverage for these groups. Less than 0.5 percent of the population has no coverage at all. This includes persons with high incomes as well as non-registered individuals such as illegal immigrants.

Sickness funds are established as 'private corporations under public law' (*Körperschaften des öffentlichen Rechts*). The sickness fund system is highly decentralised. It consists of

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a number of different types of funds. This diversity is largely the result of historical developments. In 1991, the following insurance funds existed in (western) Germany:

Table 1.1: Number and Type of Sickness Fund[15]

•	264	**Local Sickness funds** (*Allgemeine Ortskrankenkassen*), which geographically cover the entire country;
•	684	**Company-Based Funds** (*Betriebskassen*), which are set up by large companies;
•	151	**Crafts' Funds** (*Innungskassen*), which are set up by crafts' organisations[16];
•	19	**Agricultural Funds** (*Landwirtschaftliche Krankenkassen*), which are responsible mainly for farmers and their families;
•	7	**White Collar Workers Substitute Funds** (*Ersatzkassen für Angestellte*), which operate nationwide;
•	8	**Blue Collar Workers Substitute Funds** (*Ersatzkassen für Arbeiter*), which operate nationwide, or on a regional basis;
•	1	**Sailors' Fund** (*See-Krankenkasse*), for seamen; and,
•	1	**Miners' Fund** (*Bundesknappschaft*), for miners.
Total	**1,135**	**Funds**

Sickness funds fall into two basic categories. The first category mainly comprises funds which cover individuals within their geographical boundaries (local funds), crafts' funds, company-based funds, and some small special funds. These are the so-called primary funds (*RVO-Kassen*). The second category comprises all other funds which cover people in particular classes of occupation. These are the so-called substitute funds (*Ersatzkassen*). Of particular importance are the white collar substitute funds. This group comprises nationwide operating funds for certain professional groups that are open to all who qualify for membership, mainly *all* white collar workers.[17] An exception is the 'technician substitute fund' which restricts membership to technicians. By contrast, all blue collar substitute funds are strictly trade-specific. This automatically restricts membership.

Under the statutory insurance fund system, all insured people receive the following benefits:[18]

[15] Source: *Daten des Gesundheitswesen* (1991), p. 171. In 1990, the number of sickness funds was 1,147.

[16] Crafts' funds in Germany serve legally defined occupational groups, as opposed to company-based funds which serve the employees of a single organisation.

[17] Approximately 50 percent of those within the statutory insurance fund system have a choice of which fund they belong to.

[18] Health Care Act, para. 11, pp. 20-62; also, in: *Der Bundesminister für Arbeit und Sozialordnung (1990): Die Krankenversicherung*, p. 31; and Henke, 1990, p. 150.

Table 1.2: Benefits in Kind and in Cash

Benefits in Kind	Benefits in Cash
Preventive Care (Health Counselling, Annual Check-Ups etc.)	Sickness Benefits
Primary (Ambulatory) Care	Maternity Allowances
Hospital Care	Travel Costs
Dental Care	Burial Allowances
Maternity Care	
Family Planning Advice	
Physiotherapy	
Rehabilitation	
Eyeglasses	
Medical Appliances	
Rehabilitation/Preventative Care Stays in Health Care Resorts	
Medicines	

Many of the benefits in kind are free at the point of delivery, although there are exceptions. Copayments exist for in-patient care in hospitals, for medicines, and for some specialist primary services such as dentures and orthodontics treatments. Copayments tend to be small, with the exception of those for dental services. Upper reimbursement limits for prescription medicines also exist.

All benefits are listed in the Health Care Act (*Sozialgesetzbuch, 5. Buch: Die Krankenversicherung*), mainly in paragraphs 11 to 68. They are available to all insured and apply to all sickness funds. It is thus not possible for insurance funds to deny coverage of any of these services to their members. Germany thus has a well-defined guaranteed health care package. The 1993 Health Care Act slightly changed the composition of this package. Some additional services, such as transport costs and (under certain circumstances) treatment abroad, have been included in the package. Other services, such as special orthodontic treatments and vaccinations for holiday travel abroad, have been excluded from reimbursement.

Patients do not pay for physicians' services at the point of delivery. Instead, the patient hands over a form (*Krankenschein*) to the physician which forms the basis of an invoice by the physician to the sickness fund. Forms are to be replaced by a so-called sickness insurance card (*Krankenversicherungskarte*) by January 1995.

The guaranteed health care package includes not only benefits in kind, but also benefits in cash. The most important of the latter are sickness benefits. Under German social legislation, employers must continue to pay the wages of employees who have fallen ill for the first six weeks of illness. After six weeks sickness funds assume responsibility for the payment of sickness benefits. These usually amount to 80 percent of the last wage the insured earned prior to becoming ill. The fund's commitment is for a maximum length of 78 weeks at which time the insured person qualifies as a

permanently disabled person, or as a person requiring long-term care. In either case the insurance fund ceases to be responsible.

Residential long-term care is not covered by the statutory sickness funds.[19] The burden of care for these people falls either on their families, or, if this is not possible, on local government and voluntary organisations.[20] The financial burden, especially for in-patient long-term care, may be met out of the individual's pension or savings, as well as out of support from the family. Since this generally does not cover the costs of care, patients usually receive so-called welfare assistance (*Sozialhilfe*). Eighty percent of those receiving institutional (long-term) care depend on welfare payments.

The fact that no adequate cover for long-term care exists is considered a weakness of the German social security system. The Federal Government is at present debating introducing a statutory long-term care insurance, possibly on similar lines as the health insurance.

On 1 January 1990, there were 44 private health insurers covering in full or in part 11 million people in all. Of these 6.5 million had exclusively private sector coverage (approximately 10 percent of the population), while 4.5 million had supplementary coverage in addition to that guaranteed to them by the statutory sickness funds. In 1989 private insurers' expenditure on health care was DM 17 billion ($7.3 bn 1990).

1.3.3.2 Degree of Choice for the Insured

According to the Health Care Act the following groups are subject to mandatory insurance and are insured automatically, i.e. without application for admission, other than self-registration or registration by their employers:[21]

- salaried workers;
- unemployed persons (if they receive unemployment benefits);
- students (up to age 30);
- pensioners;
- farmers;
- artists; and,
- disabled persons.

Persons whose regular annual salary exceeds a certain amount (*Versicherungspflicht-grenze*; in 1992: DM 61,200 or $24,000 1990) are not required to belong to an insurance

[19] The responsibility of the insurance fund ceases when a doctor decides that in-patient care cannot improve the health status of the patient. In many cases, the decision as to when in-patient care stops and long-term care starts is a difficult one.

[20] Since 1989 sickness funds have provided financial support to help cover the costs of home care. New proposals (June 1993) would bring long-term care within the social insurance system.

[21] Health Care Act, para. 5. The Health Care Act usually specifies exactly the conditions which determine to which category a person belongs.

fund; instead they may remain voluntary members of their sickness fund, or, alternatively, opt out of statutory health insurance and buy private insurance.[22] The latter decision is in general irreversible: people cannot revert back to statutory insurance fund membership once they have left their fund unless their income drops below the specified threshold and is expected to remain there permanently. Special rules apply if the annual income of an individual is occasionally below and occasionally above the threshold. In the past, few of those who were entitled made use of the option of leaving an insurance fund.[23] There are various additional regulations on voluntary membership in statutory insurance funds.[24]

Spouses of insurance fund members are automatically covered if they earn less than a minimum threshold (in 1992: DM 500 or $195 1990 per month).[25] Dependents are automatically covered until the age of 18, or 25 for children attending university or vocational training courses. Civil servants are usually covered against sickness through the *Land* or federal government which pay part of their health expenses directly. The remainder may be covered by private insurance.

The health care legislation determines the insurance fund to which the insured belongs. For employed persons this is usually their local sickness fund. The location of their workplace, rather than their residence, determines membership of the local fund (although the 1993 Health Care Act changes this). For craftsmen the craft's fund of the employer determines membership of crafts people. Special rules apply for company-based funds. If a firm has more than 450 (since January 1993: 1,000) employees and if the existence of the local sickness fund is not endangered by the establishment of a company-based fund, a company-based fund can be founded. The foundation requires the approval of a majority of employees. Workers who enter a firm which has a company-based fund are eligible for membership of this fund.

Due to the rules of selective enrolment a large part of the population is restricted in its choice of an insurance fund. However, a segment of the population, notably white collar workers, some blue collar workers, crafts people and employees of a company which has its own fund, have a choice of which fund they wish to join.

This situation creates imbalances. Funds for white collar workers and funds for blue collar workers are known as 'substitute funds' (*Ersatzkassen*) because they offer a choice for those eligible for membership. These substitute funds therefore provide some competition for the local funds. People who qualify for membership of a substitute fund have a choice between the substitute fund and their local insurance fund. White

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22 Health Care Act, para. 6.

23 This is apparently changing, with more and more young and healthy people making use of the option.

24 Health Care Act, para. 9.

25 Health Care Act, para. 10.

collar workers in particular almost always have a choice of belonging to one of several substitute funds (the exception is the technicians substitute fund which restricts membership to technicians). Blue collar workers, on the other hand, usually only have a choice of one substitute fund only, based on their blue collar profession. The criteria for membership are becoming increasingly questionable, not least because there is no legally binding definition of what constitutes a white collar worker.

The 1993 Health Care Act mandates that all members of local funds, company-based funds and crafts' funds may chose their sickness fund in the same say as most white collar workers do at present. This new regulation will come into effect in 1996. Insurance fund members can then terminate their membership of one fund and seek membership of another. Terminations will become effective at year-end. This means that switching insurance funds will become possible from January 1997 onwards. The aim of this reform is to provide most funds with the same competitive framework. This is expected to lead to a reduction in the differences in contribution rates that are currently manifest. Premium differentiation is expected to continue, but will depend much more on the efficiency with which sickness funds conclude contracts with providers, and much less on risk differentials in the insured population.

This organisational reform of the sickness fund will have major implications for the German health care system. It means that the overwhelming majority of people will for the first time have a choice as to which fund they wish to belong.

The 1993 Health Care Act also proposes the establishment of an overall risk adjustment mechanism (*Risikostrukturausgleich*) across funds. All funds will participate in this global risk adjustment mechanism, which will be gradually implemented beginning in January 1994 (i.e. two years prior to the lifting of membership restrictions). By 1995, the risk adjustment mechanism of pensioners will be integrated in the general mechanism.

The risk adjustment mechanism will be administered by the Federal Insurance Office (*Bundesversicherungsamt*) and will be based on revenue sharing involving all sickness funds (except the agricultural funds). Risk factors to be included in the risk adjustment mechanism will initially be limited to a small number of factors and will include income, number of dependents, gender and age.

The latter regulation takes account of the fact that a comprehensive compensation scheme across insurance funds is in place which ensures an equal share for all funds for the financing of services for pensioners, albeit retrospectively. The compensation scheme eliminates undesirable differences resulting from different numbers of pensioners in individual funds. Pensioners pay approximately 17 percent of total insurance fund contributions, but account for 40 percent of their expenditure. This mechanism thus already acts as a safeguard for those funds which have a high proportion of pensioners.

To phase in the new organisational structure of sickness funds, the following regulations have also been included in the 1993 Health Care Act:

- Current membership restrictions of substitute funds will be abolished; instead, there will be open enrolment for all comers.
- Substitute funds which currently only operate region-wide will be allowed to expand to cover the entire country.
- Open enrolment will also be extended to company-based funds where currently membership is restricted to employees of the company. These funds may open up membership if they wish to do so, but do not have to introduce open enrolment. The miners' fund, the sailors' fund and the agricultural funds have been excluded from mandatory or voluntary open enrolment.
- Small (local) funds will be encouraged to merge. This process is already underway but is likely to accelerate once membership restrictions are lifted.

1.3.3.3 Funding of the Payers

The contributions which members pay to their insurance funds depend solely on their ability to pay and are calculated as a percentage of their income. The premiums are calculated as a percentage of the gross salaries up to an upper limit (in 1992: DM 61,200 or $24,000 1990) after which the premium is fixed at the maximum. This upper limit (*Beitragsbemessungsgrenze*) is set at 75 percent of the upper limit for the statutory pension insurance and is adjusted annually to coincide with the growth rate of the average income of the insured population. At present, i.e. prior to the changes mandated by the 1993 Health Care Act, the percentage charged by insurance funds differs across funds. This is due to differences in the risk structures of the funds, in the revenue bases, and in the regional distribution of facilities.

For example, in 1989 the average insurance fund contribution rate was 12.9 percent. By 1990 that rate had decreased slightly to 12.5 percent (the first decrease since 1984), and decreased again in 1991 to 12.1 percent. However, average premiums charged by different types of funds in 1991 varied in the range of 11.1 to 13.3 percent. Charges made by individual funds differed even more. Contribution rates varied between 10.8 percent (for the city of Böblingen, a suburb of Stuttgart) and 16.4 percent (for the city of Kiel in northern Germany).

The variations in the contribution rates can also be seen from the following table, which lists the annual average contribution amounts in 1988 (in DM) for various types of sickness funds:[26]

[26] Schulenburg (1991a).

Table 1.3: Contribution Rates of Sickness Funds in 1988

	DM	$1990
Local sickness funds	4,111	1,817
Company-based funds	4,372	1,932
Crafts' funds	3,365	1,487
Agricultural funds	3,098	1,369
White collar workers' funds	4,067	1,798
Blue collar workers' funds	4,230	1,870
Sailors' fund	5,659	2,501
Miners' fund	5,439	2,404

Sickness funds finance health expenditure on a pay-as-you-go basis from contributions. They do not receive additional funding from the government.[27] Sickness funds are not for-profit organisations. They do not accumulate capital reserves. Changes in premiums are decided upon at irregular intervals rather than on an annual basis. The executive board of an insurance fund takes the necessary decisions, which then have to be passed by the general assembly of the insurance fund (see Sub-Section 1.3.3.4 below) and approved by the supervisory authority, which is usually the Ministry for Labour and Social Affairs of the respective *Land*.

Employers and employees each pay 50 percent of the premium. Pensioners pay 50 percent of the contribution out of their pension; the remaining 50 percent is paid by their pension fund. For the unemployed the Federal Labour Agency pays the contributions, while for other groups (e.g. students, those in military service) special regulations are in place.

People with an income above the opt-out level, who nevertheless decide to remain members of the statutory insurance funds and are employed, also pay only part of their premium, with a maximum of 50 percent being paid by the employer. In contrast to non-voluntary members whose contributions are deducted directly from their pay cheques, voluntary members (rather than the employers) are themselves responsible for the regular payments of their premiums.

1.3.3.4 Regulation of the Payers

Sickness funds are autonomous, self-managing bodies, regulated by the government as set out in the health care legislation. Judicial cases are dealt with by a system of special courts (*Sozialgerichte*). They are generally inclined towards a generous interpretation of the rights of the insured.

[27] There are exceptions. Sickness funds which grant maternity payments are reimbursed by the federal government with a fixed fee (in 1990: DM 400).

Insurance funds are required to have the following decision making bodies:[28]

- A general assembly (*Vertreterversammlung*) which decides on the statutes of the fund and decides on such matters as the annual administrative budget, or cooperation with other sickness funds. The general assembly is elected every six years in so-called 'social elections' by the insured and their employers.

- An executive committee (*Vorstand*) which carries out day-to-day business. The executive board is elected by the general assembly.

Half the members of both the general assembly and the executive board come from the insured, the other half from employers. The general assembly and the executive board of substitute funds consist exclusively of the insured. Special rules apply to the miners' fund. The 1993 Health Care Act introduces changes to the internal organisation of sickness funds. In particular, it plans to phase out the general assembly and replace it with administration boards (*Verwaltungsrat*) which will consist of approximately 30 people. The executive committee will be replaced by a Chief Executive Officer (*Geschäftsführender Vorstand*).

The government supervises the insurance funds and ensures that all actions taken by the funds are in accordance with the law.[29] Supervising authorities for insurance funds whose areas of competence fall within one *Land* only are the Ministers for Labour and Social Affairs of the respective *Land*. For those funds whose area of competence falls within several *Länder*, the supervising authorities are the Federal Minister for Health and the Federal Insurance Office. The Federal Insurance Office must also approve the premiums of private health insurers.

Local sickness funds cooperate on several levels. On the *Land* level the local sickness funds based in one *Land* form a regional association (*Landesverband*). There are presently 264 local insurance funds in (western) Germany.[30] They form 12 *Länder* associations.[31] The number of insured members per local fund varies between 800 members (on the island of Helgoland) to more than a million. Each local fund appoints members to the *Land* general assembly and the *Land* executive committee. They, in turn, appoint members for the federal assembly and the federal executive committee.

All *Länder* associations form one federal association (*Bundesverband*). Some funds, in particular the substitute funds, form only federal associations. These associations are

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28 *Sozialgesetzbuch IV - Gemeinsame Vorschriften für die Sozialversicherung* (common regulations of the social insurance legislation), para. 29-47.

29 The government and its institutions are not allowed to impose their views on the funds with respect to abstract legal terms such as the directive for funds to "be economical".

30 There are 13 local funds in the ex-GDR (German Democratic Republic).

31 There are 5 *Länder* associations in the ex-GDR.

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also self-governing bodies whose governing institutions are similar to those of the local funds. The federal associations of substitute funds and the regional associations of other funds conclude contracts with their counterpart providers, in particular with the federal and regional associations of physicians.

1.3.3.5 Economic Incentives

Until the changes introduced by the 1993 Health Care Act come into effect, different sickness funds continue to be in different competitive situations. These differences can be described as follows: fund membership is compulsory for most people, and funds are not allowed to refuse membership to anyone who fulfils membership conditions. This means that funds cannot generally engage in *open risk selection*. However, the potential membership of some funds includes a wider segment of the population than that of other funds; these funds are therefore able to attract better risks. For example, people who are eligible for membership in white collar funds are often younger and healthier than those in the local funds. White collar funds therefore have an incentive to attract (qualifying) members, and indeed seek to do so. This behaviour can be described as a *concealed form of (positive) risk selection*.[32]

Competition is much less typical for blue collar funds. This is because they are usually small in terms of membership, as the number of blue collar workers has declined in recent years, in Germany as elsewhere. Furthermore, all blue collar funds restrict membership to workers of a specific economic sector.[33]

Company-based funds also play a less significant competitive role than white collar funds, although their contribution rates are usually comparatively low. It is therefore usually advantageous for an employee to switch to a company-based fund. Company-based funds cannot demand a health check of an applicant, but employers sometimes do so as part of the recruitment of new employees.

To summarise, the risk structure of some funds, notably nationwide operating white collar substitute funds and company-based funds, is better than that of other funds. Consequently, such funds have been able in the past to offer lower premiums to their members. At the same time, substitute funds have been able to pay slightly higher reimbursement fees to physicians.

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32 For example, while sickness funds are not allowed to advertise openly for members, they can in fact provide the general public with information on health care issues. This is sometimes mixed with concealed forms of advertisement.

33 Similar membership restrictions apply to individual funds within the group of white collar funds. However, since it is much more difficult to differentiate white collar (service) workers than blue collar (industrial) workers, the restrictions are less binding.

With the passing of the 1993 Health Care Act the Government signalled its intention to abolish the unequal competitive standing of sickness funds, and instead to put them on an equal footing. It remains to be seen whether or not the organisational reform of sickness funds will be implemented as prescribed by the 1993 Act. If the changes are implemented, and if furthermore the global risk adjustment mechanism between funds operates in a satisfactory manner, then the reforms will have succeeded in removing the incentive for some funds to pick and choose. Ideally, any remaining discrepancies in the income-related premiums between funds should then reflect efficiency differences between funds rather than variations in the risk structure of funds.

1.3.4 Primary Health Care Sector

1.3.4.1 Roles and Objectives

The primary health care sector in Germany comprises all office-based physicians and specialists (including dentists) who deliver ambulatory care. In 1990, there were 75,251 office-based physicians providing services in Germany, or 1.19 per thousand of the population. As gatekeepers to the hospital sector, they are of central importance in determining the amount of care that is to be provided to the insured.[34]

Apart from treating patients, office-based physicians provide health advice, refer patients to hospitals, prescribe medicines, and determine whether or not a patient is able to work (and thus becomes eligible for sickness benefits).

In principle, each doctor who has achieved the required educational and training qualifications has the right to set up a practice and be accredited as a physician with the sickness funds. An exception is made for doctors of 55 years of age or more, who have no such right. Doctors do not have to ask for accreditation with sickness funds, unless they wish to be reimbursed by them. Sickness funds, on the other hand, must accept all applicants. Once a doctor is accredited with a fund, he or she is accredited with all funds. Thus accreditation with selected funds is not possible.

According to the 1993 Health Care Act, physicians' right to establish practices will be subject to stricter control by the physicians' associations. Beginning in 1999, quotas will be used to determine the number of doctors allowed in any one region. The aim of this regulation is to reduce the expected surplus of doctors by curtailing their right to automatic accreditation with sickness funds.

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[34] There are approximately 37,000 practising dentists in Germany. They are organised in a similar way as physicians. The Federal Association of Dentists (*Kassenzahnärztliche Bundesvereinigung*) negotiates contracts with the sickness funds, while the Federal Chamber of Dentists (*Bundeszahnärztekammer*) acts as an interest group for dentists. The oral health care system is organised and financed in similar ways as the primary physician sector. Patient co-payments, for example for dentures, are in place. Per capita expenditure for dental care are the highest in the world.

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The availability of technological equipment in the German ambulatory sector is, by international standards, high. On average each physician has approximately five assistants, which means that many diagnostic and therapeutic treatments involving high-tech machinery can be provided. This will often include ECGs, X-rays and endoscopy facilities, or even computer-tomography, as well as a range of laboratory services.

Office-based physicians are organised in regional Associations of Accredited Physicians (*Kassenärztliche Vereinigungen*) for their dealings with statutory sickness funds. Each *Land* has one or more *Land* Associations of Accredited Physicians (*Kassenärztliche Landesvereinigung*), and there is also one at the federal level (*Kassenärztliche Bundesvereinigung*). One legal obligation of these associations is to set up a system of contracts with the insurance funds which will determine the level of reimbursement for physicians. The 1993 Health Care Act requires all contracts to be negotiated on a regional basis (usually a *Land*). Prior to the 1993 Health Care Act, the Federal Association of Primary Physicians was responsible for the contracts with insurance funds which operate in more than one *Land*.

Contracts between associations of sickness funds and associations of physicians covering reimbursement levels of the latter have to be in place at all times. This means that physicians are not allowed to strike. If the two parties cannot agree, the issue is resolved by an arbitration committee. Its non-partial chairman is appointed either by agreement or, failing that, by casting lots.

1.3.4.2 Patient's Choice within the Primary Health Care Sector

All insured persons have a free choice of physician. Patients usually see their family doctor in the first instance, who may refer them to a specialist. Patients may also seek treatment directly from a specialist.[35] Unless there is a compelling reason, a patient who sees a doctor who is not accredited with an insurance fund may have to pay the additional costs, i.e. the extra cost over and above the agreed fee of an accredited physician.

Hitherto primary and hospital care has not been well integrated in Germany. The 1993 Health Care Act appears to encourage the establishment of 'out-patient clinics' in hospitals. These would be hospital departments where people undergo minor surgery on a day-basis. The Act stipulates that free choice of physician be extended to out-patient clinics where these are established.

Certain specialties are not included in the list of treatments offered by office-based physicians. Examples of such treatments are the services of psychologists and natural (alternative) therapists. The insurance funds will only pay the costs of such treatments

[35] Health Care Act, para. 76.

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if the physician specifically requests that such treatment be provided and gives reasons for his or her request.

1.3.4.3 Funding of the Primary Health Care Sector

Primary physicians are usually paid on a fee-for-service basis, although the health care legislation also allows other forms of payment. In practice, funding of physicians is based on a relationship between a budget set at the *Land* level and the amount of work undertaken by physicians as expressed in volume terms. In detail the procedure is as follows.

On the *Land* level, the *Länder* Sickness Fund Associations negotiate a budget for the following year with the *Länder* Physician Associations. Thus physicians submit their bills to the respective *Land* association which is responsible for distributing the payments for services rendered. There are 18 *Länder* Physician Associations.[36]

On the federal level, the Federal Association of Physicians and the Federal Association of Sickness Funds negotiate a fee schedule for the services provided by physicians.[37] These fee schedules are relative value scales, expressed in points per service provided. For example, a telephone conversation with a patient may be worth 80 points, a home visit 360 points, and a radiology test up to 900 points. Detailed listings are published covering numerous services and their respective point values.

To translate the points into German Marks the following formula is applied:[38]

$$\text{Monetary Conversion Factor (Point Value)} = \frac{\text{Budget}}{\text{Points Billed By All Physicians}}$$

Monetary conversion factors may differ across groups of sickness funds, but not within groups of funds in the same *Land*. Monetary conversion factors for substitute funds have traditionally been marginally higher than those of the local sickness funds. At present, the value of a point is approximately 9 Pfennig ($0.038 1990) for local insurance funds, and 11 Pfennig ($0.046 1990) for substitute funds. For private patients the same relative value scheme is used. Physicians treating private patients are allowed to charge fees that are between 1.7 to 3.5 times the level of those paid by statutory sickness funds.

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36 There are 5 *Länder* Physician Associations in the ex-GDR.

37 Health Care Act, para. 82-87.

38 This Section describes the reimbursement process as it was until the beginning of 1992. In January 1992, a new contract was negotiated by sickness funds and physicians in which the capping of the overall physicians' budget was abandoned. As a result, physicians responded with a significant increase in the volume of treatments in the first half year of 1992, thus putting in doubt whether the new contract will actually come into effect. Meanwhile the 1993 Health Care Act a reintroduced capped budgets for physicians. This means that the situation will remain as it is described in this Section.

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The reimbursement scheme has led to a decrease in the relative income of German doctors, not least because the number of doctors has risen steadily. According to one estimate the average income earned by German physicians was 6.5 times the average income of all German employees in 1971, but it was only 3.5 times the German average income in 1991.[39]

The 1993 Health Care Act limits the increase of the overall physicians' budget for the years 1993 to 1995 to the increase in the revenue base of members of the statutory insurance system. Several treatment items, such as minor ambulatory surgery and preventative care (check ups, ante-natal care) will receive their own budgets. These budgets will also be linked to the revenue base of insurance contributions but will also receive additional funding. A separate budget for medicines prescribed by physicians has been introduced for the first time (see Section 1.3.6).

Plans to change the reimbursement method of physicians have also been introduced by the 1993 Health Care Act. Instead of reimbursing each single act which a physician performs, individual acts of services may be grouped together to form so-called service-groups (Leistungskomplexe). Physicians may therefore increasingly be reimbursed for service groups rather than fee-for-service. Furthermore, office-based specialist physicians (e.g. paediatricians) will have to decide by the end of 1995 whether they wish to be known as family doctors (*Hausärzte*) or specialists (*Fachärzte*). The aim of the latter reform is to financially upgrade service groups predominantly performed by family doctors.

1.3.4.4 Regulation of the Primary Health Care Sector

Apart from malpractice issues, regulation of the primary health care sector takes the form of checks on whether physicians provide treatment in a way which is both economic and cost-effective. To do this, sickness funds' associations and physicians' associations form regulatory committees. Membership on these committees is allocated on a bipartisan basis, with representatives from either group alternating as chairman for one year. Either party can initiate proceedings against a doctor who is considered to have provided treatment that is not economic or not cost-effective. Before any action is taken advice and counselling are offered.

The two associations also jointly audit referral patterns of individual doctors and check on the number of people taking sick-leave on the doctor's advice. This control is mainly performed on the basis of detecting significant discrepancies between the average cost of an individual doctor's services (*Arztkostendurchschnitt*) and the average cost of services of all doctors of the same specialty (e.g. all gynaecologists). In addition, more detailed checks are undertaken on a random sample basis and involve investigations of 2 percent of all doctors per quarter. This form of random checks is specifically designed to complement the average-based procedure control technique.

[39] Schulenburg (1991b).

The 1993 Health Care Act specifies auditing procedures in more detail including controls based on prescription limits.

1.3.4.5 Economic Incentives

The method of reimbursing physicians described above was intended to combine two things: fee-for-service reimbursement, and an attempt to contain costs. The fee-for-service reimbursement provides doctors with an incentive to treat all patients (and, indeed, to overtreat them). On the other hand, the reimbursement system also resembles a zero sum game. If one doctor generates 10 percent more services, his or her income might rise by 10 percent. However, if all doctors generate an additional 10 percent of service the monetary value per point must fall by 10 percent to keep expenditure within budget limits. The result is strong competition amongst physicians to expand the volume of treatment.

The introduction of service group payments, to replace fee-for-service payments, may eventually reduce somewhat the incentive for doctors to provide extra treatments beyond what would appear reasonable on medical grounds. Instead, this will give doctors incentives to choose the most cost-effective course of therapy for a treatment covered by a service group arrangement.

1.3.5 Hospital Sector

1.3.5.1 Roles and Objectives

In 1989 there were 3,046 hospitals in (western) Germany. These are divided into hospitals for the acutely ill, special hospitals, and hospitals which care for patients with long-term illnesses. Three different types of ownership of hospitals exist. They are public, private voluntary and private proprietary ownership. Each group owns approximately one third of all hospitals.

Public hospitals are owned by cities and municipalities, by counties, by *Länder*, or, in the case of special (e.g. military) hospitals, by federal authorities, or combinations of these. University clinics are always owned by *Länder* governments. Public hospitals account for 51 percent of beds; private voluntary hospitals, often owned by religious organisations, account for 35 percent of beds; while private proprietary hospitals, often owned by doctors, account for 14 percent of beds.[40]

On the lower level of city or county hospitals there is a trend amongst local authorities to establish a private company with limited liability as direct owner of the hospital. In so doing, local authorities create an institution governed by private, rather than public, law. This allows more flexibility with respect to wage setting for managers and some clinicians. It is the owner of the hospital (i.e. the municipal authorities or the

[40] Private hospitals need licences which are granted to the owners personally.

local parliament) which appoints hospital managers. In the last few years these appointments have increasingly taken the form of temporary, rather than unlimited, appointments.

Hospitals can also be classified according to categories. Categories range from I to IX, depending on the number of medical departments. Thus, category I hospitals are university clinics with at least twelve medical departments, while category IX hospitals are small local hospitals.

Several *Länder* associations of hospitals (*Landeskrankenhausgesellschaften*) exist, as well as a national organisation (*Deutsche Krankenhausgesellschaft*), but because of the heterogeneity of their members they are rather less powerful organisations than, say, the physicians' associations. One of their functions is to negotiate the annual wage increases for clinicians and nurses with their respective trade unions. In 1990 there were 96,203 clinicians working in German hospitals. They are represented in wage negotiations by their one and only trade union, the *Marburger Bund*. The *Marburger Bund* is affiliated to the German Trade Union for White Collar Workers (*Deutsche Angestelltengewerkschaft*). Unlike physicians, clinicians have the right to strike for their wage demands as long as an emergency service is in place. This, however, rarely happens. Clinicians are also organised in the *Hartmann Bund*, a political pressure group, which is also open to physicians. Participants in the wage negotiations for nurses and other hospital staff include trade unions, such as the Trade Union for Public Services and Transport (*Gewerkschaft Öffentliche Dienste, Transport und Verkehr*), churches (as owners of hospitals), the Red Cross as well as other organisations.

The internal organisation of hospitals varies, not least because of the diversity of their legal form. For public local hospitals the organisation is usually as follows: central management consists of three people; these are a clinical director, a director of nursing and a director of administration. All three directors are usually appointed by the owner of the hospital, to whom they are accountable. They are paid a salary which is usually agreed in negotiation with the owner. In the case of university clinics, the clinical director is often elected by the medical staff. Directors of administration are increasingly being recruited from the private sector, and have a background as managers, economists or lawyers. Some come from the civil service. This reflects the growing awareness that hospitals need to be run on business-type lines. It is also mirrored in the fact that salaries for these positions are now more in line with salaries of equivalent positions in the private sector, and that contracts are being reviewed regularly.

The three directors usually run the affairs of the hospital as a team, with the clinical director possibly having the final say in case of disputes. In private proprietary hospitals, the organisation may be quite different. The same holds for university clinics, where universities and research organisations often have considerable influence.

Efforts are being made to introduce clinical budgeting in German hospitals, but these attempts have not yet reached a sophisticated stage in all hospitals. The purpose of clinical budgeting is mostly directed towards improving resource allocation among hospital departments. It is generally not intended to involve doctors and nurses in the establishment of contracts with sickness funds in a systematic way. It is generally felt that hospital doctors and nurses lack the necessary skills and experience to be involved in contracting.

Incentive-based methods are increasingly being introduced in hospitals to encourage doctors to economise on resources. For example, doctors who spend less than the allocated internal budget on health care, may be permitted to spend the savings on research.

1.3.5.2 Patient's Choice within the Hospital Sector

Insured persons have a say in the choice of the hospital to which they are referred by their physician. However, the physician has to take account of two criteria:

- The hospital should offer suitable treatment for the patient; and
- it should be cost-effective.

Thus, if the doctor refers a patient to a hospital, he or she has to give reasons why this is necessary. Usually this involves referring patients to either of the two nearest hospitals, taking into account medical suitability and costs of service. To help doctors with their choice, a price list, giving *per diem* or cost-per-case rates, of nearby hospitals is usually available. If an insured person chooses another hospital without compelling reason, then the insurance fund can claim back from the patient a percentage (which may be 100 percent) of the additional costs that have arisen in the course of the treatment at that hospital compared to the cost of the recommended hospital.

1.3.5.3 Funding of the Hospital Sector

Only the following types of hospitals provide treatment to patients and are reimbursed by sickness funds:

- university clinics;
- hospitals which are part of the 'Hospital (Need) Plan' of a *Land*; and
- hospitals which have a contract with a *Land* Association of Sickness Funds.

Sickness funds may contract with public, voluntary and private (for-profit) hospitals. A flexible prospective annual budget is calculated on the basis of anticipated occupancy rates in the forthcoming year and the costs per day. This means that budgets are mainly based on *per diem* rates. A *per diem* rate is a uniform sum which the hospital receives for each day for the entire duration of the hospital in-patient stay of each of its patients. The *per diem* rate can vary for some specialties. Other treatments are

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priced on a cost-per-case basis. All patients, whether privately or socially insured, are charged directly for additional service, such as a single room, television, or treatment by doctor of their choice. Costing and pricing rules are listed in the Federal Care Ordinance (*Bundespflegesatzverordnung*). A twenty page formula (*Selbstkostenblatt*), detailing calculations and cost allocations must be filled out once a year by the hospital administration.

Hospitals and sickness funds must agree on the following rates (if they fail, a neutral non-governmental arbitration office is called in):

- General rates; these are *per diem* rates irrespective of patient categories and specialty. They inevitably lead to cross-subsidisation across specialties.
- Special rates; these are *per diem* rates for special patient groups such as obstetrics patients, burn victims, infants in neonatal care, mental patients, etc.
- Cost-per-case payments; these are for specialised treatment and surgery (*Sonderentgelte*) including cancer treatment, thorax surgery, dialysis, heart and other transplants, lithotripsy and medical innovations. Rates for specialised services are cost-per-case payments outside the budget.

For example, at the University Hospital of Hannover in Northern Germany, one of the most expensive hospitals in Germany, the rates for selected procedures are as follows (as of February 1992):

Table 1.4: Rates of Selected Procedures

	DM	$1990
1. General *Per Diem* Rate	727	283
2. Special *Per Diem* Rate		
Haemodialysis	791	308
Paediatric Oncology	990	385
Intensive Care	1,728	673
3. Cost-per-Case Payments		
Kidney Transplant	50,111	19,509
Liver Transplant	163,206	64,540
Heart Transplant	129,310	50,343
Cardiothoracic Surgery	20,035	7,800
Bone Marrow Transplant	194,057	75,550
Lung Transplant	175,043	68,148
Heart-Lung Transplant	175,043	68,148

Under the global budget, if actual bed days *(ex post)* exceed the expected bed days *(ex ante)*, hospitals receive only 25 percent of the *per diem* rate on the excess number. If the actual bed days fall short of the expected bed days the hospital receives 75 percent of the per diem rate for the shortfall. The rationale for these figures is the assumption that 75 percent of hospital's cost are fixed, and 25 percent are variable. Therefore, if a hospital does not achieve its target, it can still honour its employment contracts and other fixed cost obligations.

At present, sickness funds are obliged to meet the expected operating costs of hospitals (*Selbstkostendeckung*). The 1993 Health Care Act has changed this. Hospitals now carry the risk of not covering their costs. Hospitals can carry surpluses over into subsequent years. Deficits are usually paid by the (public) owners. If the owner is a voluntary organisation without sufficient funding, the deficit is financed by banks. Consequently, such hospitals accumulate debt over the years.

The negotiations between hospitals and insurance funds usually take place on a local level, not, as with the negotiations for reimbursement levels of physicians, on a national or *Land* level. It is the local sickness funds that usually take the lead in negotiations with local hospitals, often with a representative of a nationwide operating substitute funds being present at these negotiations. Often, several local insurance funds will negotiate jointly with a hospital. In practice, the negotiations concentrate on a percentage increase on the previous budget.

The substitute funds have much less of an incentive for tough negotiating with hospitals. Since their expenditure is distributed across hospitals nationwide, rather than concentrating on a few in a municipality, they have more opportunities to compensate cost differences among hospitals.

Hospitals always bill the local insurance fund of a patient's residence. For most funds, such 'cross-boundary' referrals and payments usually account for only a small amount of a local fund's budget. For nationwide operating funds cross-boundary payments do not apply.

Since January 1993, insured persons of age 18 or above pay a copayment of DM 11 ($4.51 1990) per day in hospital up to a maximum of 14 days. From January 1994 the copayment will increase to DM 12 ($4.92 1990). In eastern Germany copayments have been lowered from DM 10 to DM 8 ($3.28 1990) per day. As of January 1994 they will be increased to DM 9 ($3.69 1990).

Investments (including expenditure for medical technology) are financed by the *Länder* governments. This can include investments for private for-profit hospitals. Investments which lead to a rationalisation of services, and hence to a reduction of operating costs, may be financed through *per diem* or cost-per-case rates by insurance funds, rather than by *Länder* Governments through separate funds.

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Prior to 1993, investment funds were allocated solely on the basis of the number of beds in hospitals for each hospital category I to IX. For university clinics, the Federal Government (which is responsible for research) usually has to be consulted. The Ministry for Labour and Social Affairs of the respective *Land* draws up the investment plan, with the *Land* Ministry of Finance deciding on the level of funds available. Thus, *Länder* funds for capital expenditures are made available to those hospitals which have received accreditation under the Hospital (Need) Plan. Every *Land* must have such a Hospital Plan. Hospital accreditation is intended to achieve an equitable distribution of hospital facilities and available hospital beds within a *Land*, as well as a well balanced structure of hospitals. Small local hospitals are responsible for basic care while university clinics are responsible for highly specialised care. Private hospitals find it increasingly difficult to receive accreditation and thus become eligible for capital expenditure funds.

The 1993 Health Care Act introduces several changes to the hospital sector. Most notably the Act states that for the years 1993 to 1995 budgets for hospitals are linked to the growth of income of members of sickness funds. Also more *per diem* rates will eventually be replaced by cost-per-case payments. A list of treatments for which cost-per-case payments is feasible will be drawn up by 1996. Treatments for which cost-per-case payment is not feasible will be reimbursed by a tariff which separates direct medical expenses from hotel costs.

The new regulation abolishes the long-standing principle of hospital finance whereby hospitals' operating costs were reimbursed in full (*Selbstkostendeckungsprinzip*) or almost in full (flexible budget). The aim of the new regulation is to create incentives for improved hospital efficiency by basing hospital funding increasingly on prospective cost-per-case payments (*Leistungsentgelte und Fallpauschalen*).

Other changes envisaged by the 1993 Health Care Act include the following:

- The conditions under which capital investment funds may be attracted from private sector sources will be simplified and private sector finance promoted.

- Hospitals will be obliged to make better use of 'large' technical equipment facilities, such as MRI units, by sharing such facilities with other providers. Planning for new large equipment facilities will be improved and will involve better consultation among providers of a *Land*.

- The integration of primary and secondary care will be improved. This may lead to the establishment of out-patient clinics in hospitals.

1.3.5.4 Regulation of the Hospital Sector

It is possible for the *Land* associations of the sickness funds to withdraw funding from hospitals, or hospital departments, which are deemed to work inefficiently. To begin the proceedings, the *Land* association of sickness funds together with the association of private insurers and the hospital in question jointly appoint a controller to evaluate efficiency, cost-effectiveness and quality of the hospital. If no agreement is reached concerning the choice of an auditor a neutral arbitrator is called in to make this decision. The recommendations of the evaluation are taken into account at the next year's negotiations of *per diem* rates, and may eventually lead to the closure of the hospital or parts of the hospital. Under the 1993 Health Care Act these proceedings are further simplified.

There are some differences between hospitals and rehabilitation institutions. The latter do not have to be included in the hospital need plan of the *Länder*, but can contract directly with the sickness funds. Rehabilitation institutions also generally have more freedom in the setting of prices for services which they provide. Consequently, they are largely exempt from cost-effectiveness controls, but not from quality controls.

Formalised quality control has only recently been introduced into the German health system. At present it is envisaged that a committee made up of the physicians' associations, the hospital associations, and the sickness funds will formulate recommendations and guidelines for quality control.

1.3.5.5 Economic Incentives of the Hospital Sector

There are few for-profit hospitals, and most hospital managers are paid a salary. Nevertheless, the incentives of hospital managers are largely dependent upon the way the hospitals are reimbursed for the services which they provide. The incentive structure can therefore be described in four ways:

- Because payment is based on daily rates, the hospital's income is directly related to the number of patients and the average length of stay per patient. Hence a hospital has an incentive to treat all patients, as long as beds are available. It also has an incentive to provide treatment for as long as is necessary for medical reasons. But when beds are empty, there is a financial incentive to extend the hospital stay beyond the point at which hospitalised treatment is no longer strictly required. The introduction of cost-per-case payments for some services, as envisaged by the 1993 Health Care Act, will lessen this incentive.

- The incentive to keep as many patients as long as possible is compounded by the fact that if marginal costs make up less than 25 percent of the *per diem* rate, a higher than projected occupancy rate yields extra income. Furthermore, the surplus can be carried over into the next year.

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- In fact, given that the bulk of a hospital's care is often concentrated in the first days of a patient's treatment with little other than hotel care required towards the end of a patient's hospital stay, a hospital may decrease its average cost per day by keeping patients longer in the hospital than necessary. Thus, hospitals with a low turnover and long in-patient stays may compare favourably in terms of cost-per-day to hospitals with a high turnover and short in-patient stays.

- While some hospitals are run by a team of relatively independent managers, others are more closely associated with their owners (e.g. towns, municipalities or regions). In the latter case they are more likely to operate under the political influence of their owners which may affect their efficiency.

- Under the conditions of fixed budgets during 1993 to 1995, hospitals are forced to balance revenues and expenditure. Since increases in revenues are unlikely, they therefore have an incentive to reduce their costs, either by shortening the length of stay of their in-patients, or by referring (expensive) patients to other hospitals.

1.3.6 Pharmaceutical Sector

1.3.6.1 Structure of the Pharmaceutical Sector

In 1990 there were 18,500 pharmacies in Germany, of which the great majority (18,000) were retail pharmacies and the rest hospital pharmacies. These pharmacies employed 36,500 pharmacists. Any pharmacist who has acquired the necessary qualification has the right to set up a pharmacy. Each pharmacist can operate only one pharmacy. Expenditure on medicines as a percentage of overall spending on health care has remained fairly constant in recent years at around 14 to 16 percent.

Like physicians, pharmacists are organised in *Land* councils and a federal council. Councils decide mainly issues relating to education and professional standards. In addition, the Economic Associations of Pharmacies (*Wirtschaftsverbände der Apotheker*) establish agreements with the insurance funds on drug labelling, prescription rules, inventory standards, etc., but not on reimbursement levels.

In 1990, there were approximately 1,000 pharmaceutical manufacturers employing approximately 109,000 people.[41] Less than 500 manufacturers produce 95 percent of all drugs. The lowest 25 percent of all firms had an annual turnover of less than DM 15 million ($6.3 mn 1990), while the highest 25 percent had a turnover of above DM 150 million ($63 mn 1990).

[41] The figures are taken from the 1990 Annual Report of the Federal Association of the Pharmaceutical Industry, and from *Pharma Daten 1991*, also published by the Industry.

In the same year, the industry produced medicines worth DM 25.7 billion ($10.7 bn 1990), of which DM 10.6 billion ($4.4 bn 1990) were exported, while imports were DM 6.1 billion ($2.6 bn 1990). Sales in western Germany in 1990 were DM 16.2 billion ($6.8 bn 1990) in manufacturers' prices, while sales in retail prices in 1990 were DM 21.8 billion ($9.1 bn 1990) for prescription drugs, and DM 5.7 billion (2.4 bn 1990) for over-the-counter (OTC) drugs.

The industry is mainly organised in the Federal Association of the Pharmaceutical Industry (*Bundesverband der Pharmazeutischen Industrie*), which is also represented at the meetings of the Concerted Action. The Association is a member of international organisations such as the European Federation of Pharmaceutical Industries' Associations (EFPIA) and the International Federation of Pharmaceutical Manufacturers Association (IFPMA).

A survey of its members conducted by the Federal Association of the Pharmaceutical Industry revealed the following cost structure of the pharmaceutical industry in 1989 (in percent):[42]

Table 1.5: Cost Structure of the Pharmaceutical Industry in 1989

	Percentage of Total Costs
Production	41.7
Scientific Information	13.2
Advertising	4.5
Research and Development	15.0
Licences	1.6
Distribution	8.8
Administration	7.5
Other	7.7
Total	**100.0**

Patent duration in Germany is 20 years. However, given the time lag between patent application and market introduction, the effective patent protection period for medicines is very much less, on one estimate 7 to 8 years.[43] In 1990, approximately 600 patents for drugs were granted. Estimates for the number of medicines available in Germany vary, not least because of difficulties in distinguishing substance combinations and ingredients, and hence identifying different drug products. A regularly updated list, published by the Federal Association of the Pharmaceutical Industry, lists 8,429 medicines in 1991. This number is likely to constitute a lower bound for the actual number of medicines.

[42] Federal Association of the Pharmaceutical Industry: Annual Report 1990, p. 28.

[43] *Pharma Daten* (1991), p. 51.

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1.3.6.2 Funding of the Pharmaceutical Sector.

The funding of the pharmaceutical sector in Germany is shown in Chart 1.3. Medicines are distributed from the manufacturers to retailers via wholesalers and are distributed directly to hospital pharmacies. Manufacturers are free to choose the price of their products. Wholesalers can add a percentage mark-up to the price, up to a maximum which is determined by federal law in the Medicines Price Ordinance (*Arzneimittel-preisverordnung*). The maximum mark-up varies inversely with the manufacturer's price. Currently, the rate decreases in several steps from 21 percent for a manufacturer's price of up to DM 2.65 ($1.03 1990), to 12 percent for a price of DM 108.71 ($42.32 1990) and above.

The retail pharmacist is required to add a fixed mark-up to the 'hypothetical' wholesalers price; this is the manufacturer's price with the maximum wholesaler's mark-up added. This regulation ensures that prices for drugs in retail pharmacies are uniform throughout Germany. Again, the fixed mark-up decreases in inverse relation to the hypothetical wholesaler's price, this time in several steps from 68 percent for a hypothetical price of up to DM 2.40 ($0.93 1990), to 30 percent, for a price of DM 170.30 ($66.30 1990) and above.
However, retail pharmacies generally receive medicines from one to three wholesalers, and these provide quantity discounts to retailers in order to ensure long-term business relationships. The federal authorities decreed that these discounts should be passed on to the sickness funds. They estimated and calculated the average discount at 5 percent.[44] As a result, all retail pharmacists have to pay 5 percent of the hypothetical wholesaler's price to insurance funds.

Retail pharmacies are reimbursed partly by Pharmacy Data Centres (*Apotheken-rechenzentren*), which they have set up themselves and partly by patients (see Chart 1.3). There are four such data centres in Germany. These centres are then reimbursed by the insurance funds.

Manufacturers of medicines generally compete on the basis of the prices and benefits of their products. Wholesalers of medicines also compete in the setting of prices to the extent that they set margins below the maximum allowable margin. Retail pharmacists do not compete as far as prices are concerned.

Even though mark-ups on prices are degressive, the absolute difference between retail price and manufacturer's price is significantly higher for more expensive medicines. The actual wholesale price is determined in negotiation (the hypothetical wholesale price being very much an upper limit), so wholesalers and retailers divide this total

[44] In the five new *Länder* of the ex-GDR a so-called deficit reimbursement scheme was set up, whereby the pharmaceutical industry, wholesalers and retailers would reimburse the sickness funds for any occurring deficit on pharmaceutical spending in these five *Länder*. A deficit was defined as an expenditure level on drugs which exceeds 15.6 percent of the insurance fund premiums. In 1991, the deficit was approximately DM 1 billion.

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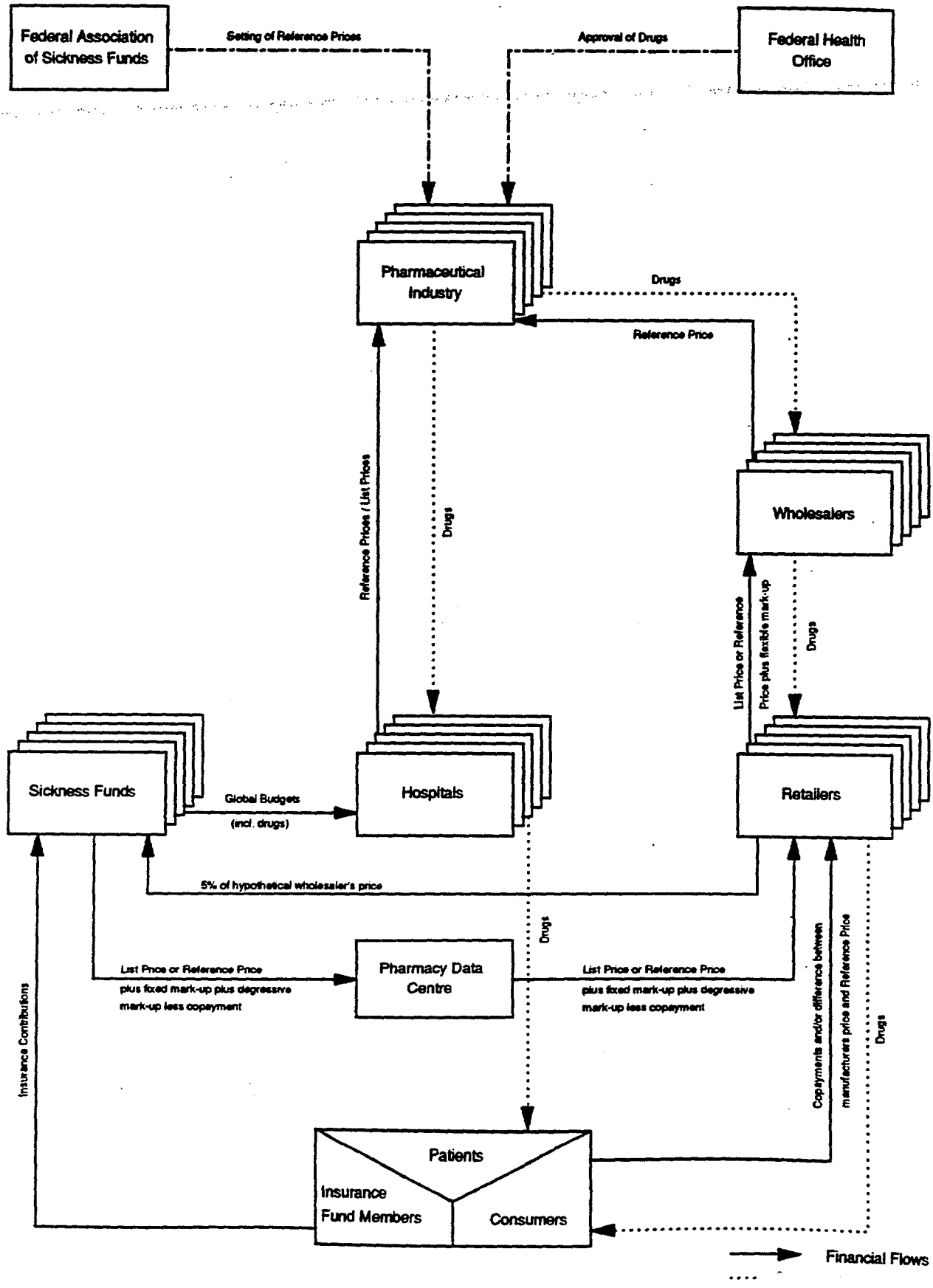
Chart 1.3
The Pharmaceutical Sector in Germany



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margin between them. Neither, therefore, has any financial incentive to keep medicine prices low.

1.3.6.3 Reference Prices

Insurance funds are required to reimburse the retailers for part of the cost of medicines. The level at which this reimbursement is set is determined by the so-called reference pricing system. This was introduced in the 1989 Health Reform Act.

Reference prices (or more correctly: fixed level reimbursement schemes; *Arzneimittel-Festbeträge*) are administratively set reimbursement levels for medicines with similar properties (see below). They are set by a federal commission comprising representatives of sickness funds and physicians, but not including representatives of the pharmaceutical industry. This constitutes the reimbursement level for insurance funds.

If an insured person wishes to obtain a medicine whose price is above the reference price, then he or she has to pay the difference between the actual price and the reference price. Furthermore, doctors have to indicate on the prescription form whether the pharmacist is allowed to hand out an equally efficacious but more cost-effective drug.[45]

The system of reference prices came into effect in 1989 and was to be developed in three groups:[46]

1. Group 1 contains medicines with therapeutically equivalent active substances.

2. Group 2 includes medicines with pharmacologically comparable active substances, especially chemically related ingredients.

3. Finally, Group 3 includes those with comparable therapeutic effects, particularly drug combinations. Originally the Health Care Act of 1989 specified that drugs with comparable pharmacological-therapeutic effects be included, but the 1993 Health Care Act changed this to comparable therapeutic effects.

The Ministry of Health originally hoped that progress would be such that by the end of 1992 80 percent of all drugs would be covered by reference prices. Patented drugs were supposed to be excluded from reference pricing, but, prior to the 1993 Health Care Act, it appeared that the distinction between patented and non-patented drugs was not always observed. Under the 1993 Act the conditions for including out-of-

[45] Patients can choose the retail pharmacy, i.e. the non-hospital based pharmacy, at which they obtain prescribed medicines. Hospital-based pharmacies are only accessible to clinicians.

[46] Health Care Act, para. 35.

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patent drugs in Group 1 have been relaxed, whereas inclusion of drugs into Groups 2 and 3 appear to have been tightened by clarifying the term 'innovative': an active ingredient is now considered innovative "so long as that active ingredient of this group which was first marketed is protected by patent".[47]

The first reference prices were introduced on 1 September 1989. By 1 January 1993 reference prices had been fixed for:

- 86 substances of Group 1 (of an estimated potential of 130 substances);
- 12 substance groups of Group 2, comprising 108 substances; and,
- 3 substance combinations of Group 3.[48]

This amounts to 45 percent of the total expenditure of sickness funds on medicines.

The administration of reference prices is complex; Chart 1.4 lists the institutions and procedures that are involved. Chart 1.4 shows that the Federal Association of Company-Based Insurance Funds (*Bundesverband der Betriebskrankenkassen*) is responsible for the calculation of reference prices. The basis for this calculation is an econometric model which aims to determine relative standard prices by regressing manufacturers' prices of drugs of the same therapeutic group on the variables 'dosage strength' and 'package size'. Standard prices are then converted into reference prices by multiplying the chosen price of a standard unit with the relative standard prices.

The reference price system is controversial not least because it is difficult to decide what exactly a therapeutically comparable effect is. Its effects on pricing of drugs are significant. Although pricing of new drugs is free upon market introduction, prices for many medicines did in fact converge to their reference price after the introduction of the new system. Since reference prices were calculated on an average basis, the prices of some medicines actually increased. Furthermore, generic drug competition almost collapsed as their prices were also brought into line with reference prices.

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[47] *MPS Intern* 6/92m p.2.

[48] Source: *Bundesverband der Betriebskrankenkassen*, 1993, January.

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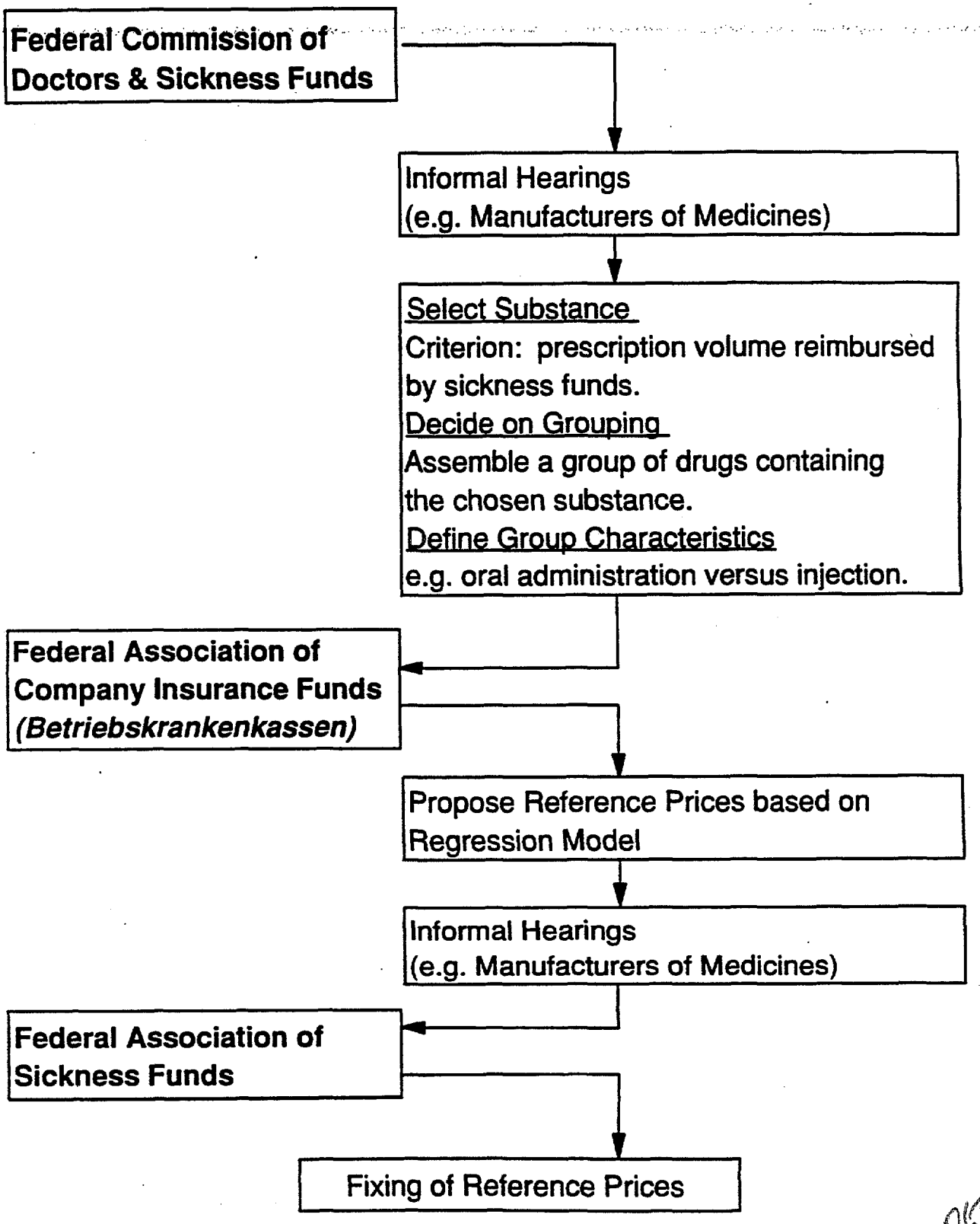
Chart 1.4
The Setting of Reference Prices



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1.3.6.4 Copayments

Prescription fees were introduced in 1970. The copayment structure has changed frequently in recent years. Initially, when reference prices were introduced, medicines covered by these were free of charges other than the difference between sales price and reimbursement level. This has changed with the passing of the 1993 Health Care Act. Patients now have to pay copayments for all medicines irrespective of whether or not they are covered by reference prices. The new structure is as follows:

- DM 3 ($1.2 1990) for medicines priced DM 30 ($11.6 1990) or less (or the full price if less than DM 3);
- DM 5 ($1.9 1990) for medicines priced between DM 30 and DM 50 ($19.4 1990); and,
- DM 7 ($2.7 1990) for medicines priced over and above DM 50.

However, according to the 1993 Health Care Act the current structure of copayments is to be replaced by yet another structure. From January 1994 the level of copayments will depend of the package size of medicines. Thus 'small' packages will have a copayment of DM 3, 'medium-size' packages will cost DM 5, while 'large' packages will cost DM 7.

In order to protect chronically ill people, or those on low incomes, the annual sum of copayments to be paid by individuals is capped at an upper limit. That upper limit is dependent upon the income of the individual, marital status and the number of children. Different limits also apply to people living in the former East Germany; this regulation takes account of the fact that income levels in eastern Germany are below those of western Germany.

Copayment limits usually apply to copayments on most services, e.g. medicines, medical appliances, medical aids and transport costs. In-patient stays in hospitals are excluded. Thus, for example, people with a monthly gross income of DM 1.484 ($590 1990) do not have to pay any copayment at all. For married couples the limit is lifted by DM 556.50 ($225 1990), and for each additional child the limit is further lifted by DM 273.00 ($109 1990). For people on lower incomes, the upper ceiling of copayments is limited to 2 percent of gross income. For income levels over and above the threshold at which people can opt out of the social insurance scheme the copayment ceiling is limited to 4 percent of gross income. These figure are adjusted for family members. For people living in eastern Germany copayment limits are approximately 25 percent below that of western Germany. Several additional regulations specifying exemption categories (e.g. chronically sick people) exist.

In practice the system of copayment ceilings is operated in a flexible manner. Chronically ill people who are unlikely to pay any copayments may receive a form

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from their insurance funds that serves as evidence that they are exempt from payment. Others who have paid more than their annual copayment limit can ask their insurance fund for a refund.

1.3.6.5 Regulation of the Pharmaceutical Sector

The Medicines Act (*Arzneimittelgesetz*) describes the conditions under which drugs may be produced. New medicines have to be approved by the Federal Health Office (*Bundesgesundheitsamt*) which has a medicines commission responsible for the approval. At present there is a backlog of approval admissions and the average procedure may take several years, depending on the type of drug. Approval procedures can be shortened if a pharmaceutical company applies for approval of a medicine which is the equivalent of an approved medicine whose patent has expired.

Some medicines, notably high-tech and biotechnological drugs, must be approved by the European Commission; once this has been secured, the drug can then be put on the market in all member states of the Community. By 1995 it is envisaged that European Community-wide approval procedures will be in place for most medicines. The details of the approval procedure are listed in the Medicines Act. There are several other ordinances which regulate the market for medicines. The Federal Health Office also decides whether or not a medicine needs to be prescribed by a doctor.

Advertising of drugs is highly regulated, even for over-the-counter medicines. For prescribed medicines, advertising is usually restricted to scientific journals and to publications for doctors, visits to hospital personnel, or seminars for health care professionals. Cost effectiveness studies or cost benefit studies are not required as part of the registration procedure.

Since 1983, there has been a list of medicines which the patient has to pay for in full (i.e. a negative list). It covers mainly OTC medicines. The negative list is to be replaced by a 'List of Reimbursable Drugs' by January 1996. To this effect, the 1993 Health Care Act plans the establishment of an 'Institute For Medicines' (*Arzneimittel-institut*). A board with eleven independent experts will be set up and will draw up the initial list of reimbursable medicines. A decision on whether or not a new medicine will be included on the list has to be made within three months of the application. If no decision is made within this time limit, the drug may be prescribed by physicians until a decision to the contrary has been made. Drugs with little therapeutic value will not be included in the list. In exceptional cases physicians may prescribe medicines which are not listed, if they give reason for their choice.

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The 1993 Health Care Act introduced two severe cost containment measures targeted at the pharmaceutical sector:

1. A price freeze on medicines not covered by reference prices was introduced. Specifically, the industry has been asked to lower prices by 2 to 5 percent from January 1993 onwards until 1994, based on price levels as at 1 May 1992.

2. A budget for medicines prescribed by office-based physicians was also introduced. This budget was set at DM 24 billion ($9.3 bn 1990) for the year 1993. The Act states that indicative budgets may also be set for 1994 and beyond, thus introducing the possibility of firmly establishing capped medicines budgets into the German health care system.

The Act rules that if the medicines budget for 1993 is exceeded by up to DM 280 million ($109 mn 1990), physicians must pay for the overrun in the following year by reducing their collective budget. The 1993 Act does not introduce individual physicians' budgets. If the budget is exceeded by between DM 280 million and DM 560 million ($217 mn 1990), it is the pharmaceutical industry which will pay for the overrun, mainly through a continuation of the price freezes agreed for 1993 and 1994.

First effects of the medicines budget appear to be significant. In January 1993, the level of prescriptions by office-based physicians dropped by some 30 percent. At present, it is not clear what the long-term effects of the new regulations will be.

1.4 INTERSECTORAL ANALYSIS

1.4.1 Major Decision Makers

The German health care system appears to be characterised by an extremely heterogenous decision making process in which numerous participants have vested interests and are often well organised in pressure groups to lobby for their interests. Physicians, clinicians and sickness funds, as well as the federal and *Länder* governments, all have varying degrees of influence. The sickness funds themselves are a heterogenous groups comprising local funds, company funds, and large nationwide operating substitute funds. Their interests partly overlap and partly diverge. Physician associations also comprise various interest groups which may not always agree on issues such as the re-evaluation of relative point values for different services (e.g. laboratory testings versus patient counselling).

However, despite the heterogeneity and multiplicity of the participants in the German health care system, the actual decision making process in the system is much less decentralised than might be expected. Two features of the system can be identified as being largely responsible for this. These are (1) the federalist nature of the key decision makers' interactions, and (2) the indirect, but strong, influence of the Federal Government on health care policies. We will briefly turn to both features.

Characteristic of the federalist nature of the German health care system is the fact that almost all key participants in it form *Land* and federal associations. It is these associations that are largely responsible for the financing decisions in the health care system. In fact, their responsibility for negotiating budgets or fee schedules is often the primary reason for their existence. The decisions which provider and purchasing associations reach are always binding for their constituency; where federal associations are involved, this is for Germany as a whole; where *Länder* associations are involved, it is for the respective *Länder*. For the negotiations on reimbursement levels, each side agrees to be represented by their association; hence, the negotiations between the associations often take the form of bilateral bargaining.

The most important decision making processes are the following:

- Reimbursement levels for primary physicians are negotiated between the federal and *Länder* associations of the sickness funds, and the federal and *Länder* associations of the primary physicians.

- Reimbursement levels for clinicians and nurses are negotiated between Trade Unions representing clinicians and nurses, and the German Hospital Association, representing hospitals.

- Budgets for hospitals are negotiated between hospitals and sickness funds on the local level. Representatives of national sickness funds may also be present.

The exception to this rule concerns pharmaceuticals. Reimbursement levels for medicines are increasingly fixed unilaterally by the National Association of Sickness Funds.

Health care is no longer the responsibility of the Ministry of Labour and Social Affairs, but rather the responsibility of the newly created Ministry of Health. As a result the influence over general policy issues that was exerted in the past by employers and employees is vanishing.

In order to guide the bargaining process of the key decision makers of the health care system, the Federal Government convenes meetings of the so-called Concerted Action (*Konzertierte Aktion*).[49] The Concerted Action has no regulatory powers; rather it exerts its influence on the basis of 'moral suasion'. Established in 1977 the Concerted Action is a national forum which meets twice annually. This top level meeting is convened by the Minister of Health and attended by representatives of the major sectors of health care. Over the years it has grown considerably, and now has approximately ninety members from various organisations (see Table 1.6).

In meetings of the Concerted Action, guidelines are agreed for the rates of increase in different types of health care expenditure (such as primary care, hospital care, dental services or prescription drugs). In general, these guidelines aim to align health care expenditure with the growth of the revenue base of the statutory sickness funds. This principle of 'contribution rate stability' (*Beitragssatzstabilität*) is actually written into health care legislation.[50] This policy of revenue-based expenditure levels has often been criticized as not being an adequate basis for health care financing decisions, because it fixes health care expenditure as a constant share of income and thus links health care budgets to overall economic activity: in times of increasing growth, more money is available for health, while in times of recession, when health care need may be greater, less money is available.

The Concerted Action also seeks to regulate the bargaining process of the federal and *Land* associations of purchasers and providers by acting as a mediator. The recommendations of the Concerted Action conference are sometimes based on expert advice commissioned by the Concerted Action from an expert council (*Sachverständigenrat*). Members of the expert council are usually academics with a background in health care and economics. They are appointed by the Minister of Health. Some economic advisors have recently pointed out that payroll deduction rate stability over the next few years can only be achieved by reducing services.

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[49] Health Care Act, para. 141-142.

[50] Health Care Act, para 71, and para 141.

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Table 1.6: Membership of the Concerted Action

Insurance Funds
1. the Federal Association of the Local Sickness Funds;
2. the Federal Association of the Company-Based Sickness Funds;
3. the Federal Association of the Crafts' Sickness Funds;
4. the Federal Association of the Agricultural Sickness Funds;
5. the Miners' Sickness Fund;
6. the Sailors' Sickness Fund;
7. the Association of White Collar Sickness Funds;
8. the Association of Blue Collar Sickness Funds; and,
9. the Association of Private Insurance Companies.

Doctors and Dentists
10. Federal Association of Physicians;
11. Federal Association of Dentists;
12. Federal Medical Chamber;
13. Federal Dental Chamber;

Hospitals
14. German Hospital Association

Pharmaceutical Sector
15. Federal Association of German Pharmacists; and,
16. Federal Association of the German Pharmaceutical Industry.

Trade Unions and Employer Organisations
17. German Trade Union Association;
18. German White Collar Trade Union;
19. German Civil Servant Association; and,
20. Federal Association of German Employers.

Governments
21. Federal Association of Municipalities;
22. the *Länder* Ministries for Labour and Social Affairs;
23. the Federal Ministry for Labour and Social Affairs;
24. the Federal Ministry for Economic Affairs; and,
25. the Federal Ministry of Health.

1.4.2 Consistency of Objectives and Incentives

The main problems areas, prior to the passing of the 1993 Health Care Act, are listed below. Since the 1993 Act envisages changes to be implemented over a period of several years, these shortcomings can be expected to persist for a number of years.

Patients, Physicians and Insurance Funds

Although the total reimbursement level for primary physicians is limited by an agreed overall budget, neither the associations of physicians nor the associations of sickness funds have any control over the volume of services provided by physicians. That volume is determined by patients and their individual physicians. Because physicians

compete with each other in this way, they have an incentive to expand volume. Patients who are fully covered against expenses are more likely to accept additional services from their physicians than would be the case if they were billed for these services.

The result has been a continuous expansion of services provided by physicians. This situation is exacerbated by the fact that the number of young physicians setting up practices has increased steadily in recent years. The increase of services generated by physicians is usually translated into an increase of the overall budget for office-based physicians in the next year, rather than a continuous devaluation of the point values for individual services.

Physicians and Hospitals

A significant feature of the German health care system is the strict division between in-patient care and ambulatory, or primary care. Prior to the 1993 Health Care Act hospitals were not allowed to provide ambulatory care. However, since in-patient treatment usually follows ambulatory treatment, procedures (such as X-rays or blood tests) are often performed twice. This lack of integration of primary and hospital services tends to duplicate effort and increase costs. The problem is exacerbated if the patient is referred from an office-based physician to a specialist physician, referred from there to a hospital and then referred back to the primary care sector. The 1993 Health Care Act introduces a number of provisions designed to improve the integration of ambulatory and hospital services.

Hospitals and Insurance Funds

Hospitals generally have their operating costs reimbursed by sickness funds. This means that hospitals are relatively free to decide what services to provide as part of medical care. This system gives the payer i.e. the sickness funds, little authority to co-determine how resources are spent, and in particular whether resources are allocated in a cost-efficient and economic way. Local insurance funds are often not in a position to evaluate whether a hospital works efficiently or not. The dual finance system of hospitals leads to a lack of coordination: *Länder* governments, which finance investment expenditure of hospitals, are not responsible for the follow-up operating costs; while insurance funds, which fund operating costs of hospitals, are usually not involved in the investment decision.

Different Groups of Insurance Funds

The selective enrolment rules of the statutory health insurance system have led to concealed positive risk-selection by some funds ('cream-skimming'), and to premium differences. Some funds could thus afford to be more inclined towards a generous interpretation of members' entitlements than others. The resulting increase in health care expenditure was passed on to fund members in increased contributions.

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1.4.3 Economic Implications for Efficiency and Equity

The German health care system is equitable as far as access to services and provision of services is concerned. Equity in the provision of services is virtually guaranteed to all Germans, regardless of age, income or status in society. The main reason for this is that most people are covered by the statutory insurance system or by private insurance schemes. Even those who, for whatever reason, fall through that net and have no coverage are usually entitled to welfare assistance payments. Despite the decentralised structure of health care provision, there are few regional imbalances in western Germany as far as service availability is concerned.

The system is, however, inequitable as far as the level of insurance contributions is concerned. Because each insurance fund is a separate self-governing organisation, it sets its own contribution level. Factors influencing the variability in insurance fund contributions include differences in the risk structure of the insured population and differences in the wage base (*Grundlohnsumme*). This has led to considerable differences in insurance fund contributions for the same level of health care services.

Under the former legislation, efficiency losses were generated in the following areas:

- Physicians were likely to provide too much treatment and patients likely to accept this over-provision. (The 1993 legislation counters this with revenue-based budgets for physician services.)

- Physicians could provide services, especially high-tech services, which were then duplicated by hospitals. Medical records often do not accompany patients who are referred to the hospital by their physician; hence patients may undergo the same procedures several times. (The new legislation remedies this situation through the introduction of provisions for improving the integration of institutional and ambulatory services.)

- Hospitals had few incentives to use resources as efficiently as possible. Sickness funds were not usually in a position to check whether the hospital provided cost effective treatment. (Hospital efficiency should improve as the result of the transition to a hospital finance system based on cost-per-case payments.)

- The relatively long length of stay in hospitals (compared to other countries) is partly due to a reimbursement method based on flat daily rates. This gives hospitals an incentive to keep patients longer than is strictly necessary on medical grounds. (This incentive will be removed under the future system for hospital reimbursement.)

- Several sickness funds are in a position to risk-select their members and do so. Sickness funds compete on the basis of generous interpretations of health care entitlements (for example with respect to the duration of rehabilitation stays in

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health resorts), rather than on the basis of premium reductions. Sickness funds often simply pass on the additional expenditure to their members. (Risk-selection will still be possible, but will have little effect on contribution rates due to revenue sharing.)

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1.5 ANALYSIS OF HEALTH CARE POLICY

In the early seventies, health care expenditure increased rapidly as a percentage of GDP causing politicians to speak of a 'health care cost explosion'. In the late 1970s, when economic recession started to erode the financial basis of the sickness funds, the Federal Government passed several health care reform acts, designed to bring expenditure under control.

Most of these reform acts were in fact cost containment acts, and introduced little structural or organisational reform. The 1977 Health Care Act, for example, focused on improving the cooperation among the participants of the health care sector by introducing the Concerted Action. Cost sharing was extended, as was the risk adjustment mechanism between funds for pensioners.

The main aim of the 1989 Health Care Act was to improve the financial performance of the system by strengthening cost-consciousness on both the supply and the demand side. Reference prices for drugs were introduced, and copayments for services were either introduced or increased. Some of the benefits in cash, such as the reimbursement for transportation to hospitals, were reduced. Sickness funds were given the right to terminate contracts with inefficient hospitals. Quality assurance and efficiency audits were also introduced.

The effects of the Health Care Reform Act of 1989 were dramatic, but short-lived. In 1989, health care expenditure as a percent of gross domestic product dropped to 8.2 percent, from 8.9 percent in the previous year.[51] In 1990 it dropped further to 8.1 percent. Since then, however, the share of GDP allocated to health care has increased sharply, and, prior to the introduction of the 1993 Health Care Act, had increased further. Similarly, the average health insurance premium, which had dropped from 12.9 percent in 1989 to 12.2 percent in 1991 had by 1992 risen to a record high of 13.3 percent.[52]

This renewed rise in health care expenditure led the coalition government of Chancellor Helmut Kohl to look yet again at health care reform. The newly appointed Minister for Health, Horst Seehofer, a member of the Christian Social Union (CSU), the Bavarian branch of the Christian Democratic Union (CDU), was given the task of proposing new reform measures. After many discussions, which involved the opposition Social Democratic Party as well as the key participants of the health care system, the 1993 Health Care Act was passed in December 1992. It came into effect in January 1993. Table 1.7 lists some of the events during the negotiation process. This serves to show how important it had become to forge a coalition among decision makers in order to put together the reform package.

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51 OECD (1991). The OECD data does not include all health care related costs.

52 Zipperer (1993), p. 25.

UNITED KINGDOM

Nera Report
White Paper "Working for Patients"
National Health Service and Community Care Act 1990

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Financing Health Care with
Particular Reference to Medicines

Volume 13

THE HEALTH CARE SYSTEM IN THE UNITED KINGDOM

n/e/r/a

National Economic Research Associates

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CHAPTER 1
PROFILE OF THE HEALTH CARE SYSTEM

1.1 SUMMARY

- Structure

The United Kingdom has a national health service. This accounts for most health care expenditure, employs virtually all doctors and provides nearly all hospital beds. Sixteen regional authorities and nearly 200 local authorities administer this national health service. The roles of these authorities are currently undergoing significant changes.

- Aggregate Level of Expenditure

The level of public health care expenditure is decided, and controlled effectively, by central government. A small but expanding private health insurance market offers supplementary health insurance.

- Incentives

Primary Care Physicians: General Practitioners (GPs) are paid mainly on a capitation basis, with some weak constraints on their budgets for medicine prescriptions, and some elements of fee-for-service. The capitation payment method may create a financial incentive to economise on the care which they themselves provide whilst nevertheless ensuring that patients receive treatment that fulfils their needs.

Hospitals: Hospital doctors are paid on a salaried or fixed time contract basis. This gives them little financial incentive to use the hospital's resources efficiently.

Insurers: Private insurers compete with one another. They are concerned about the escalation of hospital costs. They respond by offering restricted ranges of services and limiting the choice of hospital for those covered.

- Medicines

Pharmaceutical prices are not directly controlled. Manufacturers' profits are subjected to review and restraint, but within this constraint manufacturers are able to price freely. There are copayments for GPs' prescriptions, but widespread exemptions mean that only 15 percent of presriptions are subject to copayment. Generic substitution is common in hospital pharmacies.

- Issues

Total public sector spending on health care is under control at a low proportion of GDP and health care outcomes in the UK are generally similar to those in the other countries of this study. However, the combination of tight control on spending and the lack of incentives for efficient use of resources has resulted in biases in health care provision across specialities, and long waiting times for some treatments. Consequently the Government is under regular pressure to increase health care spending.

- Reforms

The NHS is currently in the throes of a major reform involving the creation of an 'internal market' by the separation of public purchasers from public providers. In addition, hospitals are increasingly becoming self-governing trusts within the NHS, and a growing number of GPs are receiving their own budgets with which to purchase hospital and other care services. These changes are intended to provide better incentives for the efficient use of resources. At this time there is only fragmentary evidence about how well they are working.

- Political Environment

The concept of universal provision of virtually all medical services free at the point of delivery is firmly entrenched. No UK political party is yet willing to contemplate limiting the range of services available. Hence the present emphasis is on improving efficiency - to get more health care for the same money. This may defer the need to restrain the growth of public health care expenditure in other ways, but it is unlikely to avoid it for ever.

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1.2 STRUCTURE OF THE HEALTH CARE SYSTEM

1.2.1 The Health Care System in Context

The UK National Health Service (NHS) was established in 1948. It is unusual in international terms to the extent that the public sector is heavily involved in both the finance and provision of health care. NHS expenditure accounts for nearly 90 percent of UK health care expenditure and around 95 percent of this is financed through general taxation and national insurance contributions. The majority of NHS services are made available to the entire population at zero user charges. On the supply side, publicly owned hospitals predominate, with a majority of doctors, nurses and other health service employees working as salaried employees for the NHS or having a close contractual relationship with it. Primary care doctors (GPs) are self-employed contractors to the NHS.

Organisationally, the NHS is accountable to the Secretary of State for Health, who heads the central government's Department of Health (DoH). The NHS itself is headed by a Chief Executive who chairs the NHS Management Executive (NHSME). Below the national level, there are 14 regional health authorities (RHAs) plus a health authority covering Wales. Separate organisational arrangements apply to Scotland and Northern Ireland. Within the English RHAs, there are approximately 190 district health authorities (DHAs) that are responsible for the provision of hospital and community health services (HCHS) and 90 family health service authorities (FHSAs) that are responsible for primary care, including general practice doctors, dentists, pharmacists and opticians. The average DHA covers a population of about 250,000 people, although individual districts range from 100,000 to over 800,000 people. District catchment areas are drawn so that each district serves either a major town and its surrounding hinterland, a large rural area covering a number of smaller towns and villages, or a portion of a large city.

The proportion of the population covered by some form of supplementary private medical insurance has nearly doubled over the last ten years (although it may have dipped slightly during the current recession). By December 1991, it is estimated that just over 12 percent of the population had private medical insurance.[1] Private sector provider facilities also increased substantially over this period. Between 1979 and 1990, the number of private hospital beds increased by over 60 percent. For the most part, however, private insurance and facilities are limited in coverage and are used to top up provision for elective procedures for which there are often long waiting times within the NHS. They do not usually cover primary health care. There is no relief from national insurance contributions or other taxes for people who buy private insurance.

[1] Laing (1992).

Undoubtedly, the major change to affect the NHS in recent years has been the implementation on 1 April 1991 of the NHS and Community Care Act. This introduced the widest ranging set of reforms that have been applied to the NHS in its forty year history. These include, *inter alia*, the introduction of an internal market for hospital services involving the separation of responsibility for purchasing health care from the responsibility for providing it, the establishment of NHS trust hospitals and community units, and the allocation of budgets to some qualifying GPs to be used for the purchase of some hospital services on behalf of their patients. Heated debates surrounding these reforms figured prominently in the political campaign preceding the April 1992 general election, with the Labour party pledged to repeal many of these provisions. However, with the re-election of a Conservative government, the new Secretary of State, Mrs Virginia Bottomley, has reaffirmed the Government's intention to continue its reform programme.

1.2.2 General Features Of The Finance System

Total gross expenditure on the NHS in 1991/92 was just over £33 billion ($49 bn 1990).[2] In addition, there was an estimated £1.5 billion ($2.2 bn 1990) expenditure on private acute health care (1991 figures);[3] Chart 1.1 illustrates (see Sub-Section 1.2.4). Taking public and private expenditure together, OECD figures suggest that the UK spends 6.1 percent of its GDP on health care (1990 figures); this represents the lowest share of all 24 OECD countries, with the exception of Greece and Turkey. (The UK figure has probably risen to around 6.4 percent in 1992.)

The sources of NHS funding are broadly as follows:

- general taxation, 79 percent;
- national Insurance, 15 percent;
- charges, 4 percent; and,
- other, mainly land sales, 2 percent.

National insurance contributions, although recorded separately, are nowadays tantamount to a tax on earned income. Employees' national insurance contributions amount to 9 percent of their income, starting at £2,808 p.a. ($3,973 1990) and up to a maximum ceiling of £21,060 p.a. ($29,800 1990). Employers' contributions are based upon employees' incomes and vary between 4.6 and 10.4 percent, depending on the income level.

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2 Throughout this Report, values are given in local currency and in 1990 US$. Conversions are made at 1990 Purchasing Power Parities. Further, figures in 1990 US$ are effectively equivalent to 1990 ECUs, for while the current $/ECU exchange rate is 1 ECU = $1.382 (Financial Times, 6 August 1992), Purchasing Power Parity in 1990 suggests a rate of 1 ECU = $1.021. Source: OECD (1992a); OECD (1992b).

3 In addition, some £2 billion (at retail prices) was spend on pharmaceutical products, including medical dressings and equipment, sold without NHS prescriptions.

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About 65 percent of total NHS expenditure is devoted to hospital and community health services, while 25 percent is devoted to family health services (FHS), covering the services of primary care providers (GPs), the costs of GP pharmaceutical prescriptions, ophthalmic and dental services. The remainder is accounted for by central services and administration.

The cash allocation for the NHS is determined each year as part of the Department of Health's allocation through the government's annual public expenditure planning process. This is a competitive bidding process in which individual spending departments submit proposals that are negotiated with the Treasury. Once an overall health expenditure level has been agreed, the Department of Health allocates the hospital and community health services budget to the 14 regional health authorities. Until 1991, this was done on the basis of a formula known as the Resource Allocation Working Party (RAWP) formula, which sought to reflect the relative level of health care needs within each region. The formula was based upon each region's population size, its age and sex composition and morbidity rates proxied by standardised mortality rates. After receiving their allocation, regions allocate budgets to the district health authorities (and FHSAs) within their boundaries. These second round allocations are partly based upon RAWP-type formula but have also relied a good deal upon less explicit, judgemental criteria and on historical factors, such as the location of major hospitals. It is the district health authorities that have been responsible for ensuring that an adequate range of hospital and community health services is made available to their residents.

With the implementation of the NHS and Community Care Act in 1991, a slightly different variant of the RAWP formula - commonly referred to as a "weighted capitation" formula - has been introduced. This system will give greater freedom to district health authorities over how they spend their allocations. In particular, they may choose to switch funding away from those hospitals which presently serve them to new ones.

The overwhelming majority of hospital and community health services are supplied to users without any charges. Where charges do apply, it is usually in connection with slightly superior hotel accommodation within hospitals, e.g. amenity beds.

Funding for primary health care is also provided through the annual DoH expenditure allocation. This is distributed through 90 family health service authorities (FHSAs) that are responsible for making payments to GPs, dentists, opticians and some services of pharmacists. The costs of medicines represent over half the total FHSA budget, although pharmacists are actually reimbursed directly from the central prescription pricing authority and not through FHSAs.

Users of GP services receive the overwhelming majority of them free of charge. In contrast, copayments have been increased quite substantially in recent years in the case of ophthalmic and dental services and also in relation to prescription medicines.

A major difference between the budgets allocated to HCHS and FHS is that the former are cash limited, whereas the latter (including the cost of pharmaceutical prescriptions) are not. Indeed, strong cash limits on HCHS resulted in a growth in volume expenditure (i.e. cash expenditure deflated by the HCHS price index) of less than one percent per year over the 1980s. Over the same period, growth in demand resulting from demographic change, and the introduction of new medical technologies, and consistent with centrally specified service development aims has been estimated to require an increase of about 2 percent per year in volume expenditure.[4] This failure of funding to match increases in demand over a prolonged period led to the cash crisis which came to a head in the Autumn of 1987. This resulted in the prime ministerial review of the NHS and, eventually, to the current programme of NHS reforms.

1.2.3 General Features of the Delivery System

NHS hospitals are owned by the public sector and are expected to provide planned volumes of care within agreed budgets. The pattern of hospital provision within the NHS has resulted from a legacy of pre-NHS hospitals and forty years of administrative planning. This has produced a general pattern in which each district has an acute general hospital, which aims to provide a comprehensive range of services. In addition, there are some specialties where the low incidence and prevalence of a particular condition, and/or the complexity of treatment, has led to the concentration of services within a small number of hospitals within each region. Renal and cancer treatments often fall into this category. Beyond this, there are some specialties - such as heart transplantation - that are organised on a national basis. Teaching is concentrated within a number of major hospitals in London and a number of provincial teaching hospitals associated with university departments.

Community health services are also organised on a district basis and comprise a range of residential, day care and domiciliary services for elderly people and for people with mental illness and mental disabilities. In many instances, community health services overlap - or have a close relation with - social care services offered by local government social service departments. One intention of the NHS and Community Care Act, 1990 was to rationalise the provision of social care. Major budgetary responsibilities, designed to enable coordinated purchasing of care, were transferred to local government authorities on 1 April 1993.

In 1989/90, there were 1,185 non-psychiatric hospitals in the NHS, with just under 300,000 beds, 6.3 per thousand of the population. This represented a reduction of around 25 percent in the number of hospitals and nearly 20 percent in the number of beds since 1979. This reduction has resulted from a conscious decision to offer care in the community rather than institutional care. However, many concerns have been voiced about the lack of adequate community services.

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4 Robinson (1991).

The NHS reforms have led to a major change in the organisation of hospital services through the introduction of an internal market and NHS trusts. From April 1991, all hospitals have been required to compete for service contracts from purchasers (i.e. districts, GP fundholders and private patients). Furthermore, NHS trust status means that hospitals and other provider units - while still remaining within the NHS - have greater autonomy than they had when they were under district control. Fifty-seven units became trusts in April 1991, and another 103 acquired this status in April 1992. The government intends that all units will eventually become trusts.

Doctors work in NHS hospitals on a salaried basis. However, it is common for senior medical staff (consultants) to hold contracts which allow them to engage in private practice - which is paid on a fee-for-service basis - in addition to their NHS work. Consultants holding full-time NHS contracts are permitted to earn up to 10 percent of their gross income from private practice. Consultants on part-time contracts are able to engage in private practice without restriction on their earnings by giving up payment for at least one NHS session per week.

In July 1990, there were also 216 private and voluntary acute medical/surgical hospitals, containing 11,000 beds. This compares with 150 hospitals and 6,671 beds in 1979. These hospitals are mainly staffed by NHS doctors undertaking private practice on a part-time basis. Nursing and other staff, however, are usually employed exclusively within the private hospital.

Primary care within the UK is based upon general practitioners. These are formally independent contractors but the terms of their contracts are subject to tight specification and regulation by the Department of Health through family health service authorities. They are paid through a complex formula which is based upon capitation payments, practice allowances, target payments and a small element of fee-for-service. GPs act as "gatekeepers" to secondary care so that a GP referral is usually required in order for a patient to see a hospital specialist, except in emergencies.

In April 1991, 300 GP practices became fundholders. This means that they receive annual budgets (deducted from district allocations) with which they can buy designated hospital services directly on behalf of their patients. In April 1992, another 300 practices joined the scheme. This means that about 14 percent of the population is now covered by GP fundholding arrangements. A further substantial increase is expected in April 1993, following a further reduction in the minimum size threshold for fundholding practices.

1.2.4 Inputs and Outputs of the System

The latest Departmental Report of the government's expenditure plans breaks down the projected NHS expenditure figures for 1991/92. Expenditure on the cash-limited hospital and community health services and that part of family health services expenditure that is also cash-limited accounts for 77 percent of net expenditure. The

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non-cash-limited family health services budget accounts for about 19 percent of the total. Expenditure on medicines represented about 50 percent of family health services expenditure. Capital expenditure amounted to just over 6 percent of total NHS expenditure. The sources of NHS funding, and the distribution of expenditure by sector are shown in Chart 1.1.

Some notable features of hospital, community and family health services activity over recent years include:

- growth of in-patient activity of 1.7 percent per year over the period 1978 to 1990/91 despite very tight hospital funding;

- reductions in average length of in-patient stay of 3.1 percent per year and an increase of 6.9 percent per year in the number of day cases treated over the same period;

- reduction of 16 percent in GP patient list sizes between 1978/79 and 1990/91. An average GP now has a list of around 1,900 patients;

- a rise of 27 percent in courses of general dental treatment from 1978/79 to 1988/89 followed by a fall of 11 percent from 1988/89 to 1990/91;

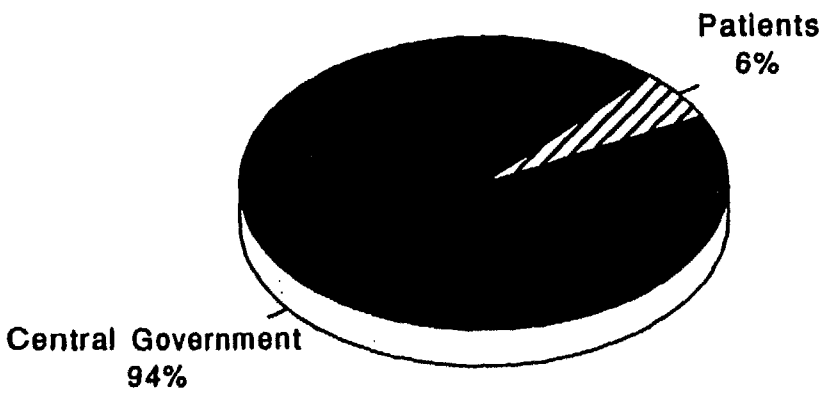
- a fall of two-thirds in the number of NHS sight tests between 1988/89 and 1990/91; (note: free eye tests were abolished on 1 April 1989, except for children under 16, low income groups, etc. Charges for tests are now typically between £10 ($14 1990) and £15 ($21 1990));

- a 22 percent increase in the number of prescriptions for medicines issued between 1978/79 to 1990/91 and a fall in the percentage of prescriptions that were chargeable from 35 to 15 percent over the same period. Rising numbers of elderly people and in the numbers of people in receipt of social security benefits - both of whom are exempt from charges - appear to be the main reasons for the fall in the proportion of chargeable prescriptions.

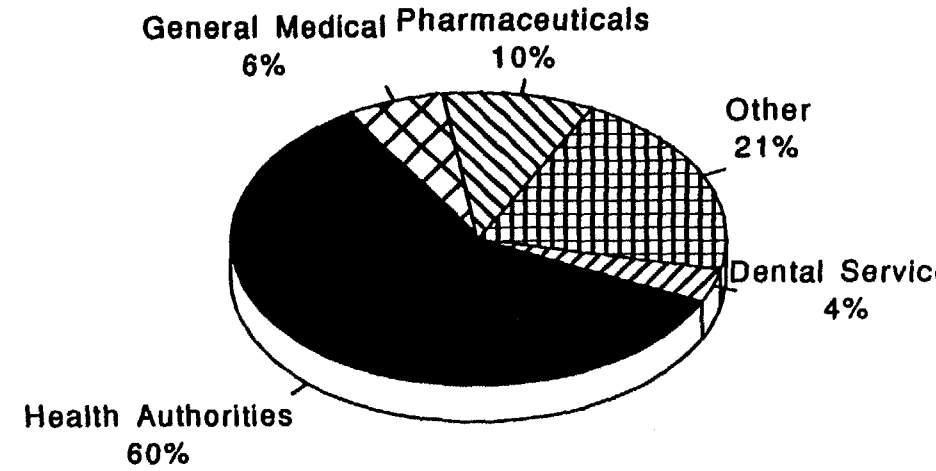
Comparing health status measures for the UK with those of other European countries and the US, indicates that the UK has by no means the best record, but that its performance exceeds that of the US in terms of male life expectancy at birth, infant mortality and perinatal mortality rates.

Chart 1.1
Expenditure on Health Care by the UK NHS, 1989/90

By Source
Total Spending: £25.5 billion



By Sector
Total Spending: £25.5 billion



Source: Department of Health: Health and Personal Social Services Statistics, 1991, p.15, 16

1.3 ANALYSIS OF INDIVIDUAL SECTORS

1.3.1 Key Participants in the Health Care System

The key participants dealt with in this section of the report are:

- patients;
- payers;
- the primary health care sector;
- the hospital sector;
- hospital clinicians; and,
- the pharmaceutical sector.

The main relationships between these participants, and the flows of finance and services between them, are shown in Chart 1.2.

1.3.2 Patients

There are approximately 57 million people in the UK who are eligible for the services of the National Health Service. These services are provided, for the most part, free of charge. Around 12 percent of the population have some form of additional private insurance cover for a specified range of services. These usually cover elective medical/surgical procedures for which there are often long NHS waiting times.

1.3.2.1 Attitudes Towards the Health Care System

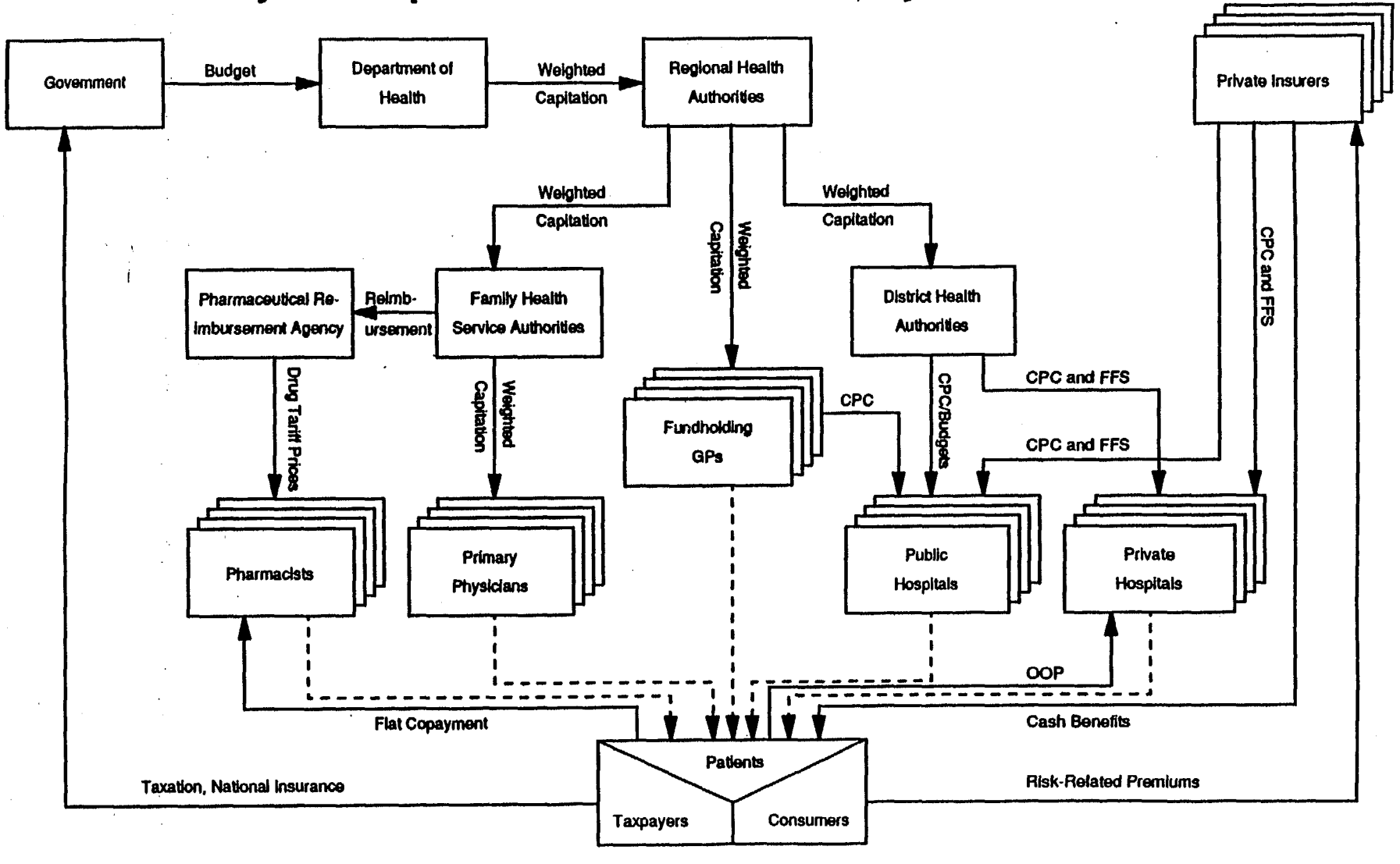
The National Health Service is generally held in high regard in the UK. As an institution, it commands wide support and is often referred to within the UK as "the envy of the world". These public attitudes constitute a real political constraint on the scope for reform of the NHS.

Nonetheless, various public opinion polls have revealed growing levels of dissatisfaction with the performance of the service.[5] Since 1983, the British Social Attitudes Survey has asked random samples of between 1,600 and 3,100 people about their levels of satisfaction with the NHS in general and with specific services in particular. Selected results of this survey are reproduced in Tables 17 and 18 in Annex 1. The question posed in relation to the general service is:

> "All in all, how satisfied or dissatisfied would you say you are with the way in which the NHS is run nowadays?"

[5] Solomon (1992); Judge et al. (1992).

Chart 1.2
Key Participants in the Health Care System in the UK



Financial Flows

Service Flows

CPC: Cost-Per-Case
FFS: Fee For Service

Respondents ticked boxes according to whether they were very satisfied, quite satisfied, very dissatisfied or none of these. Between 1983 and 1990 the proportion of people reporting dissatisfaction nearly doubled.

In all but one survey year, the general question was followed by more specific questions about satisfaction with particular aspects of the service. Respondents were asked:

> "From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the NHS runs nowadays".

The most dissatisfaction is expressed in relation to hospital services. While dissatisfaction with other areas of the health service remained at more or less the same low levels during the 1980s, the proportion of people expressing dissatisfaction with out-patient attendance at hospitals rose by one-third, and the proportion dissatisfied with being an in-patient doubled. Most notably, there is a high absolute level of dissatisfaction with hospital out-patient attendance, with about 30 percent of respondents consistently expressing such dissatisfaction since 1986.

It is noticeable that dissatisfaction with specific services, even hospital out-patient attendance, is lower than dissatisfaction with the NHS as a whole. This finding is confirmed by findings carried out by the National Association of Health Authorities and Trusts (NAHAT) since 1985. Questions asking about respondents' overall opinion of the NHS in their area recorded between 65 and 75 percent of the sample expressing positive sentiments. However, when questions are related to satisfaction with actual treatment received, satisfaction levels are consistently in the 84 to 87 percent range. These differences may have arisen, in part, as the result of a number of high profile media campaigns and political debates highlighting deficiencies within the NHS which have taken place in recent years. These have often focused upon problems caused by underfunding. This publicity seems to affect popular perceptions about the NHS but these perceptions are often not borne out by those who actually experience the service.

1.3.2.2 Roles and Objectives of the Patient

The views of patients concerning NHS services can be presented formally to the district health authority that is responsible through Community Health Councils (CHCs). There is one CHC for each district health authority. Each council has a volunteer chairperson and members, and is able to employ a full-time secretary with a small amount of public funding. CHC representatives (usually the chairperson) have special rights of attendance and participation at health authority meetings. Their concerns usually relate to individual cases or issues and, in particular, to complaints. In addition to CHCs, there is a range of pressure groups and voluntary organisations, typically associated with particular patient groups, that lobby on behalf of their members. There is also a National Patients Association.

Department of Health guidance to district health authorities attaches particular importance to the need to consult the public and to obtain their views as a basis for purchasing strategies.[6] Within the NHS, this can be seen as an alternative means of eliciting consumer preferences to that offered by a market-led system. The experiment with public consultation that is taking place in Oregon, USA, particularly its use of public meetings and community fora, has attracted a good deal of positive interest.

During 1991, the Government published the Citizen's Charter. This is a code of practice that is designed to make all public service providers more attentive to the needs of users. In 1992, the health service contribution to this general initiative was published in the form of a Patient's Charter.[7] The Patient's Charter sets out in an explicit form seven existing rights patients have in relation to NHS services. These include rights to be referred to a hospital consultant, to be given a clear explanation of proposed treatments and rights of access to medical records. In addition, the Charter sets out three new rights: namely, rights to information on local health services, including quality standards and maximum waiting times; guarantees of admission for treatment no later than two years after being placed on a waiting list; and, rights to have complaints fully investigated by the relevant health authority's chief executive.

Furthermore, the Charter contains nine national standards. These cover such aspects of care as privacy; information; waiting times for ambulances, accident and emergency services, and out-patient clinics; and discharge arrangements. The Charter also makes provision for the implementation of local standards.

1.3.3 Payers

About 95 percent of NHS funding is provided by general tax revenues (including National Insurance contributions). Charges represent about four percent of the total. They mainly apply to prescriptions for medicines, dental and ophthalmic services for which there have been substantial increases in charges in recent years. (The remainder comes mainly from land sales).

The government is the final arbiter of the UK's total (public) health care spending. Once this is determined, funding for the NHS is allocated to the Department of Health which then distributes it to regional health authorities. These, in turn, distribute it to district health authorities, family health service authorities and GP fundholders who all purchase services on behalf of their patients.

Under the pre-1991 unitary system, district health authorities were both purchasers and providers of care in the sense that they received an annual budget allocation and were responsible for providing a range of services for their district population from that

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6 NHSME (1992).

7 Department of Health (1992b).

budget. One of the features of this system was that it provided few incentives for efficiency. One observer who reached this conclusion was the US health policy analyst, Alain Enthoven, who published a highly influential monograph on the subject in 1985. His proposed solution was the establishment of an internal market, in which district health authorities would be free to buy and sell services from each other. The NHS reforms introduced in April 1991 built upon the Enthoven proposals.

Under the reforms, the responsibility for purchasing secondary health care is separated from the responsibility for providing it. On the purchaser side, there are three main agencies that will, henceforth, be responsible for purchasing health care. These are:

- district health authorities;
- GP fundholders; and,
- private patients' insurance plans and direct purchase.

1.3.3.1 District Health Authorities

DHAs are formally headed by a board of directors, comprising a non-executive chairman, five non-executive directors (all appointed by the Secretary of State) and five executive directors. They are responsible to the Department of Health and independent of local government. When the reforms are fully operational, each district will receive a cash-limited budget based upon the size and characteristics of its population (at the moment, budgets are moving towards this target allocation over, typically, a five year period). It is the district's responsibility to use its budget to purchase services on behalf of its population.

Purchasing involves a number of related tasks. First, districts are responsible for assessing the health care needs of their populations. Second, having established a picture of health care needs, districts are required to prioritise between them. It is recognised that budgets will never be sufficient to meet all health care needs and that choices will have to be made on the grounds of clinical- and cost-effectiveness. Third, districts have been required to develop contracting arrangements for the services they wish to purchase from providers. Finally, districts are required to monitor provider performance. To date, monitoring has been primarily concerned with financial performance, i.e. making sure that actual quarterly activity and expenditure meet planned levels. However, great emphasis is being placed upon the need to extend this function to allow quality to be monitored in the future.

1.3.3.2 GP Fundholders

Alongside district purchasers, the NHS reforms gave larger general practices the opportunity to apply for fundholder status. This involves "top slicing" part of the district's budget and allocating it to GPs so that they can buy a range of designated hospital and community services directly for patients registered with them.

Currently, any practice with over 7,000 patients may apply for fundholder status. Services that fundholders can buy include diagnostic tests, out-patient services and a defined group of in-patient and day cases, such as hip replacements and cataract removals. The more expensive and complicated types of hospital treatment are excluded. As in the case of districts, GPs who opt for fundholding are free to take out service contracts with hospitals of their choosing and, in some cases, to substitute their own services for existing hospital ones.[8] From April 1993, the purchasing scope of fundholding GPs will be extended to include some community health services.

Three hundred and six GPs became fundholders in April 1991. The average fundholding practice comprised just over five GPs and had a list size of 12,200 patients. The total budget allocated to fundholders amounted to £404 million ($596 mn 1990), with £208 million ($307 mn 1990) available for expenditure on hospital services. With the total HCHS budget amounting to over £18 billion ($26.6 bn 1990), fundholders' total purchasing power - at only about one percent of the total - was obviously marginal at that early stage. However, total spending figures conceal the fact that fundholders' purchasing power can be an important part of hospitals' incomes in the case of certain specialities, and it is this power that fundholders are already exerting in order to gain improved services for their patients.[9]

In April 1992, another 300 practices became fundholders. This means that now approximately 6.7 million people, or 14 percent of the population of England and Wales, are covered by fundholding arrangements. Prior to the recent general election, the future for fundholding was uncertain, as the Labour Party was pledged to abolish it. However, now that this prospect has disappeared, the number of practices seeking to join the scheme in April 1993 could almost double the existing number of fundholders. Clearly, what was initially a marginal part of the NHS reforms has become a major part of them. This poses a number of problems for efficiency and equity that are discussed later in this report.

1.3.3.3 Private Patients' and Insurance Plans

Ministerial statements preceding the publication of the White Paper, Working for Patients - which formed the basis of the subsequent NHS and Community Care Act - emphasised the case for greater pluralism within the UK health care system. Low levels of private expenditure were cited as one of the reasons for low levels of total expenditure on health care in the UK. Part of the response to this problem was the introduction of tax relief on private health insurance premiums paid by, or on behalf of, elderly people.

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8 Glennerster et al. (1992).

9 *Ibid.*

In recent months, possibly because of government sensitivity to charges of privatisation in the run-up to the general election, the case for expanding private insurance has not been made so strongly. Nonetheless, the reforms do identify private patients' and insurance plans among the purchasers within the new style NHS market.

Private insurance has expanded quite rapidly in recent years. Premia are often paid by employers, although employees are taxed on the imputed income. By December 1990, 6.7 million people, or 11.7 percent of the UK population, were covered by private medical insurance in the UK. This represented a growth in the numbers of insured people of over 30 percent between 1985 and 1990. Payments to providers in 1990 amounted to an estimated £977 million ($1,527 mn 1990).[10]

The private insurance market is dominated by two non-profit private health insurers, BUPA and PPP, which account for 78 percent of total market subscription income. BUPA's share has, however, fallen from 59 to 49 percent over the last five years. At the same time, the growth of commercial (with-profit) private insurers has been quite marked over the same period; they now represent about 11 percent of the market. Many of them are concentrating on policies which supplement NHS services, for example where NHS waiting times are lengthy; such focusing helps to hold down premiums. All private insurers risk select; they adjust premiums to take account of age, sex and existing health status.

In 1990, private spending on independent hospitals and clinics amounted to £847 million ($1,324 mn 1990), while £404 million ($631 mn 1990) was paid in fees to surgeons, anaesthetists and physicians. Private spending on NHS services, in the form of payments for pay beds, private out-patient treatment and payments by overseas visitors, amounted to £113 million ($177 mn 1990).

The bulk of this expenditure goes upon acute medical/surgical in-patient and out-patient work. Abortion is the most common procedure carried out in independent hospitals. Demand is also high for those elective procedures for which NHS waiting times tend to be longest, e.g. hip replacements, hernia repairs and treatment of varicose veins. By 1988, however, about one-third of operations carried out in independent operations were classified as major or more complex. There is also a small but growing high-technology component; for example, an estimated 2,600 coronary artery bypass grafts were carried out in 1986.

1.3.3.4 Economic Incentives

The key payers in the NHS internal market are the purchasers: District Health Authorities. However, purchasing has only been taking place for two years. Many of the functions described above are still in only embryonic form. Nonetheless, at least three factors of economic significance are worthy of note. First, although the potential

[10] Laing (1992).

presented through purchasing has captured the imagination of many managers within the NHS, and they seem to be seeking to do a good job, there is no financial incentive/sanction structure to encourage them to perform well: there is only the traditional management accountability system. That is, there are no financial incentives to match those which have been introduced through competition between providers on the supply side. (Providers are not-for-profit but face the possibility of contraction or closure if contracts cannot be agreed).

Second the separation of purchasing and providing has meant that many purchasing authorities are very small in size and have found it difficult to recruit senior people with the appropriate skills for carrying out their tasks. Skills in public health medicine that are necessary for needs assessment are in particularly short supply, as are health economists, whose skills are relevant to the task of prioritisation. An increasingly common response to this difficulty has been to merge districts' purchasing activities - this, however, runs the danger of making them remote from their populations.

Third, although the rhetoric accompanying the NHS reforms has emphasised increased patient choice, consumers have limited choice between hospitals and no choice between districts which purchase on their behalf (other than that offered by moving their place of residence to another district).

Other important payers are the FHSAs and fundholding GPs. FHSAs channel funds to the primary care sector according to pre-determined formulae. The NHS reforms have given them greater flexibility and discretionary powers than they held previously, but their functions are essentially communication, supervision and control.

GP fundholders have much more discretion about how and where their patients are treated. However, they face only limited financial incentives. Any efficiency savings they make may be invested in the practice (e.g. to improve facilities) but may not be used to supplement their personal incomes. However, as independent contractors, they could ultimately benefit when they sell their partnerships on retirement.

1.3.4 Primary Health Care Sector

Primary health care in the UK is organised around a well-established system of general practice doctors. In 1990, there were 27,523 GPs in England and Wales, 0.6 per thousand of the population. Most of these were in partnerships of two or more partners, with approximately one-third working in practices of five or more partners.

Patients consult their GPs for medical advice, diagnosis and treatment and for referral to hospital care. Compared with many other countries, the range of diagnostic procedures and treatments that GPs carry out in the UK is very limited. For example, few GPs will have X-ray facilities or specimen testing equipment. The latter will usually be carried out on the GP's behalf by a central pathology laboratory. For the most part, GPs confine themselves to standard tests and treatment of minor illnesses

(usually through drug therapy), and refer most non-standard cases to hospital specialists. There is scope for GPs with the relevant qualifications to carry out minor surgical procedures in their offices - for which they receive special payments - and this practice is growing, but it is still very small scale.

Medical students who wish to become GPs must complete the standard course of medical education and, in addition, follow a vocational training course. Once qualified, doctors who wish to set up in general practice usually do so by becoming a junior partner in an existing practice. The establishment of new practices is governed by the Medical Practices Committee. This committee seeks to achieve an even distribution of practices between different parts of the country and does so, primarily, by restricting the setting-up of practices in areas that it considers to be already well served. In 1986, this meant that it placed restrictions on the establishment of new practices in areas where there were 2,100 or fewer patients per GP. In fact, this restriction covered 92 percent of existing GPs and so meant that they were effectively protected from new competition.

Patients are required to register with a particular GP practice and subsequently must visit that practice for their primary health care needs. Exceptions occur if, for example, a patient is taken ill away from home when a local GP will usually respond. Whereas, traditionally patients have been able to change the GPs with whom they are registered, the system was highly bureaucratic. Consent needed to be obtained from the accepting GP, from the GP whose practice the patient was leaving and medical records cards needed to be processed by the Family Practice Committee. The NHS reforms have sought to simplify the process of changing GPs. Moreover, the general emphasis placed upon consumerism has led most GPs to become more proactive in distributing literature about their practice, its partners and the services they offer.

GPs provide the overwhelming majority of their services free of charge to patients. They are paid through their local FHSA. GPs' actual fee and allowance levels are set by the government following the advice of an independent Pay Review Body. This Body makes its recommendations after hearing representations from the relevant professional associations, although these recommendations are not binding on the government and, in a number of recent years recommendations have either been delayed or not implemented in full.

In 1990, a new payment structure for GPs was introduced. The 1990 contract aims to place greater emphasis on capitation payments in order to "reward GPs who give high priority to attracting and keeping patients by providing a high quality, comprehensive service".[11]

Under the new contract, at least 60 percent of GPs' fees and allowances are paid in the form of capitation payments. Patients over 75 years of age and those under 5 years of

[11] Department of Health (1989b).

age attract extra capitation payments. In addition, there are a range of other payments, including: target payments payable when particular rates of childhood immunisation and screening for cancer of the cervix are achieved; additional basic practice allowances for GPs working in deprived areas; sessional fees for running health promotion clinics; night visit fees; and payments for minor surgery.

The introduction of GP fundholding has meant a major change for the GP practices involved. The funds allocated to fundholders are, however, effectively "ring-fenced" for purchasing hospital services and cannot be used to supplement GPs' personal incomes.

GPs' activities are regulated by Family Health Service Authorities. As part of the NHS reforms, each FHSA has appointed an independent medical adviser who is responsible for liaising with GPs and improving their performance. Most medical advisers have identified GP prescribing of medicines as an activity requiring their early attention. There are at present large variations in prescription rates between GPs, and medical advisers are focusing on high prescribers in order to examine their practices.

Sandier (1990) reports information on the number of visits per GP per year, the average length of consultation and the number of hours worked per week for selected countries. Her data indicate that in comparison with, for example, the United States, France and Germany, GPs in the UK receive more visits per year and spend less time per consultation. They also work fewer hours per week. The fact that British GPs receive more visits seems to be at variance with expectations based upon the incentives offered by fee-for-service in comparison with a capitation system. On the other hand, the shorter consultation period and shorter working week is consistent with theoretical expectations.

1.3.5 Hospital Sector

1.3.5.1 Structure

In 1989/90, there were 1,185 non-psychiatric hospitals in the NHS in England containing 270,334 beds. This represented 5.7 beds per 1,000 population. Around three-quarters of the hospitals contained less than 250 beds. Just over 100 hospitals had more than 500 beds. In addition, there were 461 psychiatric hospitals with 70,627 beds. In 1991, there were 216 independent hospitals with operating theatres in the UK. These contained 10,911 beds.

Most NHS hospitals are managed by district health authorities, although under the NHS reforms which were implemented in April 1991, around 150 hospitals have become NHS trusts. These hospitals are still within the NHS but are run by boards of trustees outside of district health authority control.

The majority of hospital doctors work on a salaried basis, although a large proportion of the most senior doctors (consultants) have contracts which enable them to undertake private work in addition to their NHS work. In 1989, there were 398,054 whole-time equivalent nursing and midwifery staff in the NHS. Nurses account for almost a quarter of the total NHS budget. Nursing is regarded as a professional activity with entry qualifications and a career ladder.

Until the NHS reforms were introduced in April 1991, most NHS hospitals were directly managed by their district health authorities. Annual budgets were allocated to each hospital and they were required to deliver a generally agreed range of services from within this budget. This system contained few incentives for efficiency and so, not surprisingly, many examples of inefficiency arose.

The Government's response to these inefficiencies has been to introduce an internal market in which competition between hospitals for service contracts is expected to act as a spur to greater efficiency. This represents a major change in culture for most hospital managers and clinicians. At the moment, there is still some uncertainty about how hospitals will respond to this change and a wide diversity of experience.

1.3.5.2 Hospital Management

Part of the uncertainty about hospitals' reaction to change arises because hospitals are complex institutions that pursue multiple objectives, many of them non-financial.[12] In most organisations, managers can be expected to specify objectives in terms of sales, profits, growth or other financial variables and to devise strategies to meet them. However, the division of professional responsibilities within an NHS hospital, especially the presence of doctors with clinical responsibilities, makes it far less easy to ensure that everyone works towards a common financial objective.

Recognition of the pivotal role of doctors in committing hospital expenditure has led to successive attempts to include them formally in management decisions about the use of resources. The latest attempt - the Resource Management (RM) initiative - has been adopted for nationwide application as part of the NHS reforms. RM involves the introduction of organisational structures - usually based on clinical directorates - that involve doctors and nurses in management decisions, including budgetary control. This is seen as a key requirement if hospitals are to be able to respond to the incentives offered by a competitive external environment. Progress with RM to date has, however, been limited. A three year evaluation of six experimental sites, funded by the Department of Health and carried out by independent academic researchers, suggests that "it is still not possible to provide a definitive assessment of RM as an ongoing working process for hospital management".[13]

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12 McGuire et al. (1988).

13 Packwood et al. (1991).

1.3.5.3 Hospital Contracts and Prices

Contracts provide the formal link between purchasers and providers of health care. They are the mechanism for funding the providers and for ensuring that the services demanded by health authorities are actually supplied to them by providers. During the first year of the reforms, contracts have been based upon three main categories: block, cost and volume and cost-per-case.

Block contracts offer access to a defined range of services and facilities in return for an annual fee. Block contracts were particularly well-suited to the first year requirements because they were able to reflect, albeit in contractual form, levels and patterns of activity that were already taking place. They were also relatively undemanding in terms of information requirements. However, they give providers little incentive to increase efficiency in order to generate more income.

A cost and volume contract specifies that a provider will supply a given number of treatments or cases at an agreed price. Greater emphasis is placed upon services defined in terms of outputs, i.e. patients treated, rather than in terms of inputs, i.e. the facilities provided. If the number of cases exceeds the cost and volume agreement, extra cases have usually been funded on some (marginal) cost-per-case basis.

Cost-per-case contracts are defined at the level of the individual patient. Because they obviously involve greater transactions costs than the other contract types, health authorities have mainly used cost-per-case contracts to fund treatments that fall outside of block or cost and volume contracts. However, it is worth noting that cost-per-case contracts allocate more of the financial risk to the purchaser (who picks up the effect of variations in volume). Referrals by GPs to providers with whom districts did not have prospective contracts, and services provided for GP fundholders, have been the main form of purchasing covered by cost-per-case contracts. Such contracts do give hospitals an incentive for efficiency; they have the opportunity to increase their income by improving productive efficiency: the efficiency with which a specified treatment is supplied.

As might be expected, the overwhelming majority of contracts taken out in the first year of the reforms (1991/92) were block contracts. It is estimated that they represented 83 percent in terms of volume and 94 percent in terms of value of contracted services for acute care.[14]

Department of Health guidelines on the prices which hospitals can charge are highly prescriptive. They state that they should be based upon average total costs, that there should be no planned cross-subsidisation between services and that marginal cost

[14] NAHAT (1992).

pricing is only appropriate in cases where there is short-run, unused capacity.[15] Moreover, each hospital is expected to earn a six percent return on the current value of its assets.

During the first year of the reforms, costing and pricing was rudimentary. Few hospitals had previously had much experience with costing their services in a way that would form a basis for pricing. They were urged to keep costing systems simple and to treat refinement as an evolutionary process to be undertaken as information systems were developed. Attempts to disaggregate costs into fixed and variable elements were seen as a medium term, rather than a short term, objective. Similarly, the development of more detailed case mix costing was not seen as feasible in the short run. Where it was considered necessary to take some account of changes in case mix, a broad banding of procedures or the use of average length of stay as a proxy for complexity, was recommended. Clearly, costing remains at a fairly crude level and this is, no doubt, one of the main reasons why huge variations in prices charged by different providers for similar procedures are still reported.

1.3.5.4 Capital Charges

Since April 1991, both NHS trusts and hospitals that remain under direct district control have been required to pay capital charges - comprising interest payments and depreciation charges - to regional health authorities and/or the Department of Health. Charges are based upon the value of their capital assets and must be included in the prices that purchasers pay for services. This practice represents a major departure for the NHS.

Previously, capital assets, once acquired, were treated as a free good. There was no requirement for hospitals to meet the annual costs of capital. This undoubtedly led to inefficiency in the allocation and utilisation of capital assets. Capital charges will provide the price signals that are necessary to ensure greater efficiency in the use of the capital stock. There is already widespread anecdotal evidence that this is causing stringent reappraisal of investment plans.

1.3.5.5 Capital Expenditure

Capital funding for the NHS is determined through the public expenditure planning process, at the same time that operating expenditure is determined. It too is cash-limited. Early discussions about the new freedoms that trust hospitals would receive led many people to believe that they would be able to raise additional capital funds in the financial markets as long as they were able to service the debt. It is now clear, however, that the specification of external financing limits by the Department of Health will prevent this freedom from materialising.

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15 Department of Health (1989a).

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In the past, capital funds have been distributed to districts by regional health authorities. Demand has always exceeded supply. As such, a mixture of administrative, political and economic (cost-benefit analysis) criteria have been used to determine annual allocations of the available funds. Under the internal market system, however, different criteria will need to apply. In particular, capital plans will have to be assessed in terms of their financial viability and their place in providers' business plans, as well as more general cost-benefit considerations.

1.3.5.6 Private Hospital Sector

In 1991, there were 216 independent hospitals with operating theatres in the UK. These contained 10,911 beds. The private sector experienced a boom during the late 1970s and early 1980s, with bed capacity increasing by over 50 percent between 1979 and 1984. Since 1984, however, the number of beds has increased by only about 8 percent, and actually fell slightly between 1990 and 1991. In recent years, occupancy rates have also fallen, as a result of the recession. This is now threatening profitability. AMI, for example, reported occupancy rates of only about 60 percent in 1990.

The NHS also has 3,000 dedicated pay beds. These are beds in normal NHS wards that may be used for treating private patients. In fact, these beds are unpopular with private patients and only achieve occupancy rates of around 30 percent. However, the NHS is responding to the opportunity to generate income from the private sector by investing in dedicated pay bed units. It is estimated that there were 24 of these units at the end of 1991, containing 566 beds.

1.3.5.7 Economic Incentives

Even under the new internal market system, NHS hospitals are not allowed to make a profit on any of their services; prices have to be based on average cost, without any cross-subsidisation. Hence, profit signals, as indicators of efficiency and pointers to resource allocation, are still absent from the system. The main incentive for efficiency is the fear that if prices are not competitive they will lose contracts and have to shed staff or even, eventually, close.

Those NHS hospitals which are managed by trusts are essentially in the same position, but with the added fact that they are responsible for their own financial viability. This requires them to scrutinise closely the cash flow implications of their actions. Given that, in practice, they can also themselves use additional cash generated by efficiency improvements, cash flow considerations may, for trust hospitals, provide a partial substitute for profit incentives.

Senior hospital doctors, who in practice take most of the spending decisions, are generally salaried and so have no direct financial incentive to use NHS resources efficiently. Current attempts to make them more cost-conscious centre around involving them more closely in the management of hospitals.

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Private hospitals can now contract with purchasers to provide services to NHS patients. So far, there has been little growth in this market and so there is no indication as to whether this will significantly affect the type and cost of services they provide. However, given the present low occupancy rates in many private hospitals, it does seem likely that they will make some response to this freedom.

1.3.6 Pharmaceutical Sector

1.3.6.1 Structure

The UK pharmaceutical market was the fourth largest in Europe in 1990, accounting for about 10 percent of Western European sales. It was also the sixth largest market in the world, taking an estimated three percent of total world sales.

Spending on medicines in the UK accounted for 10.8 percent of total health expenditure and 0.7 percent of GDP in 1986.[16] UK prices were 18 percent above EC average levels, while consumption per capita was about two-thirds the EC level.

Most medicines are prescribed through the NHS by general practitioners. These are prescribed on a standard NHS form by brand or generic name. In 1989, a total of 436.2 million prescriptions were dispensed in the UK at a cost of £2.7 billion ($4.4 bn 1990). This represented an average cost per prescription of £6.25 ($10.69 1990) and a per capita cost of approximately £48 ($79 1990). About 83 percent of all NHS prescriptions were dispensed free of charge to groups exempt from payment; these include those over retirement age, children under 16 and those receiving various social security payments. The remainder have been subject to a flat rate charge of £3.75 ($5.30 1991) since April 1992. Alternatively, patients could purchase a "season ticket", covering an unlimited number of prescriptions during a period of four to twelve months. Annual season tickets are priced at about the cost of 13 individual prescriptions.

During the 1980s, prescription charges were raised on a number of occasions. Between 1979 and 1988, they increased in real value by over 550 percent.[17] A number of studies have examined the price elasticity of demand on the basis of these price changes. Separate studies by O'Brien (1981) and Lavers (1983) estimated that a ten percent increase in prescription charges resulted in a reduction in utilisation of around one percent (i.e. there was an estimated elasticity of utilisation of -0.1). More recent work by Ryan and Birch (1988) compared utilisation per capita between exempt and non-exempt adult non-elderly groups for the period 1975 to 1985. They estimated that a ten percent increase in charges led to a 1.8 percent reduction in demand (e = -0.18).

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16 Burstall (1990).

17 Birch (1988).

The NHS reforms of 1991 introduced indicative prescribing budgets for GPs. These budgets are based upon the average budgets for GPs in particular areas, after taking account of any special circumstances. GPs who exceed these budgets are called upon to justify their expenditure to the independent medical adviser of their FHSA.

A Selected List Scheme restricts the number of medicines available on NHS prescriptions. There is also a negative list of branded products and non-medicines which may not be prescribed under the NHS.

The Department of Health periodically mails to doctors leaflets containing cost comparison charts for the same or similar pharmaceuticals within a particular therapeutic group. The aim is to highlight price differences. The British National Formulary (BNF) is written by the Royal Pharmaceutical Society of Great Britain and the British Medical Association, and is mailed bi-annually free to all doctors. The BNF lists all registered products by therapeutic class, and includes outline information and comparative prices. The Drug and Therapeutic Bulletin is produced by the Consumers' Association and is mailed free to all doctors. The Monthly Index of Medical Specialties (MIMS) lists all proprietary products; it is mailed free to all doctors monthly.

The UK has a well-established pharmaceutical industry with a strong research base. Five of the UK's multinational companies ranked among the top fifty companies worldwide in 1990, and its pharmaceutical industry accounts for about five percent of world production.

The industry is at pains to emphasise the need to protect and promote its research base. Short-term cost containment policies are seen as a threat to longer term research and the benefits it produces.

1.3.6.2 Distribution of Drugs

Approximately 94 percent of prescriptions written by NHS GPs are dispensed through retail pharmacies. There were approximately 12,300 retail pharmacies in the UK in 1991. Retail pharmacies must be run by a qualified pharmacist and are generally privately owned, although there is an increasing number of pharmacy chains. Pharmacies are registered with, and inspected and controlled by, the Royal Pharmaceutical Society of Great Britain. The siting of retail pharmacies is under health authority control. Almost all retail pharmacies work under contracts to the NHS. These contracts are issued by the local FHSA.

Some GPs have dispensing rights. These apply in rural areas if a practice is more than one mile from a retail pharmacy. NHS contracts for dispensing doctors are issued by the local FHSA. Approximately six percent of NHS prescriptions come through dispensing doctors.

Most hospitals also have a pharmacy. This pharmacy is administered by a District Pharmaceutical Officer, who is responsible for the maintenance of professional standards and all aspects of hospital policy regarding medicines. Generic substitution is generally practised in hospitals.

The NHS hospital pharmacy service dispenses nearly all prescriptions written by hospital specialists, since these work from a hospital base. The hospital pharmacy has, therefore, a considerable impact on use of medicines, since regimens originated by the specialist are often continued by the GP when the patient is returned to his or her care.

Most district health authorities have Drug and Therapeutic Committees, on which hospital pharmacists play an important role in promoting rational prescribing policies. This, coupled with the practice of ward pharmacy, means that pharmacists play an important role in the selection and use of medicines. Prescriptions issued for out-patients are usually dispensed by the hospital pharmacy. However, dispensing of hospital prescriptions by retail pharmacies is becoming more common.

1.3.6.3 Regulation of the Pharmaceutical Sector

The UK is unique among European countries in controlling the profitability of pharmaceutical companies, rather than the prices of their products. This control is operated through the Pharmaceutical Price Regulation Scheme. Each year, firms negotiate with the Department of Health for a global return on capital based upon their sales to the NHS the previous year and forecasts of sales and costs for the following year. Providing that this rate is not systematically exceeded, firms are free to set their own prices. Any company making a particularly high contribution to the UK economy (in terms of exports, R&D and local manufacture) may be allowed to earn a higher than average rate of return. Reimbursement prices for medicines prescribed under the NHS are listed in the Drug Tariff. Prices are based upon average current market prices.

Overall control of policy on medicines is the responsibility of the Medicines Control Agency (MCA). The MCA was previously part of the DoH, but in July 1991, it became an independent agency reporting to the Department. Its responsibilities include pharmaceutical regulation and registration, inspections and monitoring. One of its expert committees, the Committee on Safety of Medicines, advises at the registration stage of new medicines on grounds of quality, safety and efficacy.

There has been concern over government policy regarding patent term extensions. Pharmaceutical patents are available for products and processes. Patent protection lasts for twenty years from the date of filing. However, effective patent life is measured from the time at which a product enters the market and this was only about eight to ten years in the late 1980s. In April 1991, the government announced its intention of limiting pharmaceutical patent term extensions to thirteen years, instead of the maximum of sixteen years provided for under the proposed EC Supplementary Protection Certificate Scheme. The government's rationale was to try to achieve a

compromise between supporting R&D-based companies and encouraging generic manufacture. This policy was not, however, popular with the industry and the Association of the British Pharmaceutical Industry raised strong objections to the Government's stance.

1.4 INTERSECTORAL ANALYSIS

1.4.1 Major Decision Makers

The major decision makers on the funding side are:

- voters/taxpayers/consumers;
- government;
- regional health authorities;
- district health authorities;
- GP fundholders; and,
- private insurers and patients.

The major decision makers on the provider side are:

- hospital managers;
- hospital doctors; and,
- GPs.

1.4.2 Consistency of Objectives and Incentives

There is potential conflict and inconsistency between several of these actors.

1.4.2.1 Voters/Taxpayers/Consumers

The consumers of health care are also tax payers and voters. Consumers face zero money prices for most NHS services; however, the price elasticity of demand for most of them is likely to be low. While there are non-money prices involved in consuming many free services (e.g. waiting times in GP surgeries) that serve to limit demand, there is excess demand for many hospital elective procedures and services, as evidenced by waiting lists. Excess demand could possibly be removed by greater expenditure, but this would involve higher taxes.

Whether this conflict will be resolved is unclear. Buchanan (1965) put forward the theory that NHS consumers - faced with zero prices - will demand more services than they are willing to pay for as taxpayers. This results in excess demand and non-price rationing through queues. Although there are a number of shortcomings in Buchanan's original formulation, it does draw attention to the fact that a tax-funded, collective health care system is subject to political decision making and will not necessarily be able to deliver the volume of services that consumers demand, albeit that these demands are distorted by the absence of prices related to costs.

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1.4.2.2 Government

At the national level, spending on the NHS is determined as part of the public expenditure planning process, in negotiations between the Department of Health and the Treasury. Expenditure is determined in the light of departmental needs and the Treasury's macro-economic requirements regarding public expenditure. Control of aggregate expenditure is tight; spending over-runs are, in total, trivial. If public expenditure is seen as a reflector of the wishes of taxpayers, then it appears that willingness to spend more on NHS is low. This may be in conflict with the wishes of the same taxpayers as consumers, although the availability of private health services to supplement the NHS where individual patients are willing to pay provides a significant safety valve.

1.4.2.3 Regional Health Authorities

Regional Health Authorities receive a budget from the Department of Health on a formula basis. They are responsible for allocating funds to their districts. Regional objectives tend to be specified in terms of general health planning aims, although the allocation of capital funds to districts is subject, *inter alia*, to cost-benefit appraisal. Regional general managers are accountable to the Chief Executive of the NHS through an annual management review process. The role of RHAs in the current NHS is at present rather unclear and they may come into conflict with DHAs.

1.4.2.4 District Health Authorities

District Health Authorities have traditionally been responsible for delivering health care to their populations. The general manager's objectives can be summarised as: meeting centrally specified targets, living within budget, avoiding external and internal conflicts. Since April 1991, districts have become purchasers. They are now generally charged with maximising "health gain". This concept is not, however, clearly defined. District managers are accountable to the regional general manager through an annual management review process. There is a small element of performance-related pay. Under the current system, DHAs may come into conflict with GP fundholders.

1.4.2.5 GP Fundholders

GP fundholders purchase services on behalf of their patients. Their main objective seems to be to provide good health care for their patients, and the main incentive, job satisfaction. There is little direct financial incentive for a fundholder other than those faced by other, non-fundholding, GPs. But there is the possibility of earning extra funds, improving facilities and so attracting more patients and increasing the capitation element of remuneration. If they attract more patients, they reduce the patient base of the DHA in which they are situated. If they grow to sufficient size, they may reduce the power of DHAs to bargain with suppliers of care.

1.4.2.6 Private Insurers and Patients

Private insurers pursue a range of financial and other objectives. They are involved in commercial transactions with providers and seek to obtain value for money in the normal way. They purchase most of their services on a fee-for-service basis and have, therefore, been concerned in recent years about cost escalation.

1.4.2.7 Hospital Managers

The chief executive of a provider unit has the dual objectives of winning service contracts and ensuring that agreed activity levels are delivered within budget. Individual departmental managers have similar activity and budgetary responsibilities for their departments. The incentives faced by these managers are similar to those facing managers in most large corporations, although the high political profile of the NHS imposes additional constraints. Also, because of the relatively powerful position of hospital doctors, managers may have less effective control than they would in many other businesses.

1.4.2.8 Hospital Doctors

Hospital doctors are salaried employees, although they enjoy a high degree of professional autonomy. They are usually employed by the hospitals if it is a Trust hospital, and generally by the health authorities otherwise. The Resource Management system requires doctors to be involved in the management process. As such, their main corporate aim seems to be to deliver high quality care, to be recognised as part of a successful team, and to generate income to provide essential equipment and administrative/secretarial back-up support. Personal financial incentives offered within the NHS undoubtedly play a part in influencing doctors' behaviour but they are largely based on the assessment of professional performance. Hence, their behaviour is largely based on professional expectations and, in any case, extra NHS earnings are likely to be modest in comparison with the sums that senior doctors can earn through additional private practice. It has sometimes been claimed that consultants have an incentive to keep their waiting lists long as this increases demand for their private work. However, there is no hard evidence on this subject.

1.4.2.9 General Practitioners

GPs face a number of direct financial incentives. Capitation payments are used to encourage them to attract patients; target payments are used to encourage various preventative and screening activities; payments are made for night visits; and, there are special allowances for GPs setting up in deprived areas.

Capitation systems are sometimes thought to encourage unnecessary hospital referrals as the GP has no additional financial incentive to treat a patient. Within the NHS, there

are wide variations in the rates at which GPs refer patients to hospitals[18] but there is no evidence that overall referral rates are excessive because of the capitation payments system. When considering the incentives structure, it has to be borne in mind that a hospital referral is not totally costless to the GP. It involves both time and paperwork. There is also the knowledge that, in the light of excess demand for many treatments, there will be a considerable waiting time for non-urgent referrals.

1.4.3 Economic Implications for Efficiency and Equity

1.4.3.1 Markets, Competition and Efficiency

The radical nature of the NHS reforms has meant that they have attracted a good deal of attention from economists and others. Much has been written about the likely consequences of the reforms.[19] All of these accounts, however, are based primarily on theoretical predictions and, to the extent that they draw on empirical evidence, this is usually from abroad. To a large extent, this is inevitable because the UK has had no previous experience with the quasi-market organisation that is being introduced into the NHS.

However, the King's Fund is sponsoring seven projects that are currently monitoring different aspects of the reforms[20] and there are other projects looking at such aspects of the reforms as the operation of GP fundholding. This section of the report draws on some of the theoretical and empirical issues that have been highlighted in this work.

It is the government's belief that supply-side competition will increase choice, quality and productive efficiency:

> "A funding system in which successful hospitals can flourish ... will ensure a better deal for the public, improving the choice and quality of services offered and the efficiency with which these services are delivered".[21]

Certainly, evidence from the United States suggests that, because of monopolistic market structures in the supply of hospital services, competition often takes place in terms of quality and amenity rather than price.[22] Whether such competition will be able to take place on this basis in a cash-limited system such as that found in the UK

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18 Bradlow et al. (1992).

19 See, for example, Culyer et al. (1991).

20 King's Fund Commission (1992).

21 Department of Health (1989a).

22 Robinson and Luft (1987); Luft et at. (1986); Zwanziger and Melnick (1988).

is less clear. Some economists have argued that cost-reducing strategies will be more important and that, in the event of a cost-quality trade-off, quality will suffer.[23]

Other work has questioned whether competition can be expected to lead to greater efficiency in view of the existence of local monopolies of hospital services in many areas of the country. However, an empirical study of the potential for competition in one regional health authority suggests that this issue may have been over-estimated.[24] This study used the Hirschman-Herfindahl Index to calculate the degree of market concentration among 39 NHS hospitals offering general surgery in the West Midlands region. Applying the threshold adopted by the US Department of Justice - in its assessment of anti-trust cases - to the index, it found that around one-quarter of hospitals operated in markets where the degree of concentration was great enough to suggest that monopoly or oligopoly power might exist.

However, Department of Health officials no longer assert that competition alone is expected to create greater efficiency. They point also to the importance of contestability. That is, it is not necessarily the existence of actual competitors that stimulates efficiency but rather the threat of new entrants to a market if existing firms fail to operate efficiently and/or if they make monopoly profits. In fact, the existence of considerable sunk costs within most hospital markets means that there are significant barriers to entry to new firms. This throws doubt on the applicability of contestability. However, Culyer and Posnett (1991) have pointed out that contestability could be applied to hospital managements as well as hospitals themselves, and that efficiency could be stimulated in this way. The experience of certain parts of the private sector, and of the public sector in Australia, suggest that this mechanism already takes place to some extent.

To date, however, there are no UK data which establish an actual link between competition and efficiency in the NHS. The link remains an *a priori* expectation on the part of the government. At the same time, there is no doubt that the establishment of a market in hospital services, and the contracting that this has involved, has imposed considerable costs upon the service over the last two years. Once again, neither the set-up costs nor the running costs have been quantified in any precise fashion, but the undoubted scale of the expected ongoing costs has led some economists to question whether the efficiency gains from competition will ever be great enough to offset them.

Indeed, operating the market will inevitably involve the continuation of a substantial level of transactions costs and it has been pointed out that as health care markets are characterised by bounded rationality, asset specificity and opportunism, the transactions costs approach would suggest the desirability of internalising transactions within a

[23] Barr et al. (1989).

[24] Appleby and Little (1990).

single organisation, rather than using a market-based approach.[25] (In other words, some people think it would be cheaper to have a National Health Service!).

1.4.3.2 NHS Trusts

The devolution of decision making to the local operational level is one of the government's declared aims for the NHS reforms. The establishment of NHS trusts is a key component of this strategy. With greater management autonomy, competition between trusts for service contracts is expected to increase efficiency.

Some independent experts are less clear that this will occur. The breakdown of the NHS as a monopsony buyer of labour has been pointed to as one reason for expecting competition between trusts for scarce labour skills to drive up the costs of wages and salaries.[26] Casual evidence on the salary levels being offered to trust senior managers seems to bear this prediction out, to some extent.

Little is known about the relative operational efficiency of trusts and non-trust hospitals to date. Newspaper headlines highlighting trust financial problems during the first year of the reforms were misleading as they rarely had much to do with the establishment of trust status. Early evidence from one of the King's Fund research projects, examining the relative costs of trust and non-trust hospitals, suggests that trust hospital unit costs may indeed be lower than non-trusts, but that this was the case before these hospitals acquired trust status and, therefore, cannot be attributable to it.[27]

1.4.3.3 GP Fundholding

GP fundholding represents one of the potentially most radical aspects of the NHS reforms. The concept was clearly influenced by the experience of health maintenance organisations in the United States. Unlike HMOs, however, fundholders are much smaller - typically covering only 12,000 patients - and bear far less financial risk. In the case of fundholding, budgets are based upon prospective capitation payments but these cover only a limited range of hospital services and, moreover, there is a stop-loss provision which means that any patient costing the practice more than £5,000 ($7,075 1990) in a year has the excess met from outside the fundholder's budget.

Nonetheless, a good deal of interest has centred on the budget setting process and the incentives it provides.[28] During the first two years of the scheme, budgets had been

25 Bartlett (1991).

26 Barr et al. (1989).

27 Le Grand and Bartlett (1991).

28 Glennerster et al. (1992).

set on the basis of historic utilisation levels and costs. This is likely to have rewarded higher referring practices and to have penalised low spending ones, whether efficient or not. For the future, it is intended that a risk-adjusted capitation formula will be developed; however, this is still at an early stage of development.

One of the main benefits expected from fundholding was increased responsiveness of hospital providers to GPs' wishes. Evidence from a case study of ten practices during the first year of fundholding suggests that these benefits are already being realised in small but significant ways.[29] These benefits include changed patterns of hospital referrals to obtain shorter waiting times for patients; consultants visiting GP practices and holding out-patient clinics there; faster turn-round times with pathology laboratory testing and results; and, generally, a greater willingness on the part of hospital consultants to liaise with fundholders over courses of treatment.

However, the very success that fundholders have achieved in acting as advocates for their patients has raised problems. Widespread criticism has centred upon the alleged growth of a two-tier system, with patients of fundholding practices receiving preferential treatment at the expense of non-fundholder patients. In response to these criticisms, the Secretary of State was prompted to issue a directive which prohibited hospitals from offering terms to fundholders that disadvantaged non-fundholder patients. This incident provides an example of a possible conflict between efficiency and equity aims in the provision of health care.

Moreover the fragmentation of purchaser power amongst many fundholders may, some think, seriously reduce the ability of health authorities to carry through nationally-set health policy objectives.

1.4.3.4 Regulation of the Market

When the NHS reform proposals were first published, they were heralded as a radical move towards a more market-based system of health care. However, as the implementation phase has proceeded, it has become clear that initially at least the market will be quite tightly regulated to ensure that a series of economic and non-economic objectives are met.[30] The treatment of NHS trusts, the capital charging system and the future of London hospitals all provide examples of market regulation.

When the NHS reforms were introduced, the freedom for trusts to borrow from both the public and private sectors in order to fund capital expenditure was seen as an important element of their newly acquired autonomy. From the potential trust's perspective, this was seen as a means of addressing a long-standing problem; namely,

29 Glennerster, op cit.

30 Robinson (1992).

the tight restrictions imposed by the Department of Health on their ability to undertake capital programmes.

However, the more sagacious commentators always saw greater freedom over borrowing as problematic. As part of the public sector, trusts' borrowing forms part of the Public Sector Borrowing Requirement. As such, the Treasury was bound to maintain a close interest in their activities. In the event, these reservations were confirmed. Each of the 57 units which became first wave trusts in April 1991 had their borrowing limits - known as external financing limits - set by the Department of Health in a way that had exerted tight control on their ability to raise funds. Similar, if not stronger, constraints applied to the 103 second wave trusts that came into existence in April 1992. These controls are unlikely to be relaxed as long as macro-economic management of the economy requires the government to be able to regulate public sector borrowing.

It was pointed out earlier that capital charges will provide the price signals that are necessary to ensure greater efficiency in the use of capital stock. However, the introduction of capital charging could pose problems for those hospitals occupying expensive sites and for the districts purchasing services from them. For the first two years of the reforms, these problems have been avoided, because each district has received a revenue allocation which has been adjusted in line with the capital charges it is expected to meet from the hospitals and other units providing it with services. Hence, each district purchaser has received the cash necessary to meet its own individual capital charges bill. The result is that in this initial phase the overall effect of capital charging has been neutral.

In the longer term, however, the system is not intended to be neutral. For capital charges to influence the way in which capital assets are used, it will be necessary to remove the protection presently received by providers with above average capital costs. This will be achieved by allocating revenue expenditure to districts on the basis of national average capital charges instead of the actual charges they incur. In this way, districts purchasing from high cost providers will find that they are able to buy a lower volume of services than comparable districts facing lower cost providers.

However, the Department of Health recognises that a rapid move to such a system could prove to be highly disruptive. To meet this objection, transitional arrangements have been developed in order to phase in capital charging over a number of years. Beyond this, it is recognised that some hospitals will continue to incur higher capital charges in the longer term because of factors beyond management's control. This looks likely to result in some hospitals continuing to receive assistance (subsidisation) over a longer period. Inner London hospitals will, no doubt, fall into this category, as their capital charges are over 50 percent higher than those incurred by comparable hospitals in the remainder of the South East. While it may be quite legitimate to regulate the market in this way, careful consideration needs to be given to the balance between access and the cost-efficient location of resources.

London has been mentioned as a special problem because of its high cost hospitals. In the past, however, a number of residents from outside London have been treated at the main London teaching hospitals and the revenue necessary to cover their costs has been allocated directly to these hospitals. Under the new arrangements, revenue allocations will be distributed directly to the patient's district of residence. These districts may choose to treat patients locally and thereby withdraw money from London. This potential re-allocation of purchasing power could provide powerful incentives for the contraction of facilities in London. The possible closure of one or more London teaching hospital has been widely discussed.[31]

Recognising this possibility - and no doubt the political danger associated with an unplanned run-down of hospital facilities in London - the Department of Health appointed a commission, under the chairmanship of Sir Bernard Tomlinson, to investigate and report on the future of health services in London. His report was published in October 1992.[32] It recommended the closure or merger of several London hospitals with additional resources going to primary and community care.

Clearly, there are good reasons for taking a strategic view about the future of London hospitals. The unregulated introduction of market forces could lead to disorderly adjustments of a kind which might threaten essential services. In these circumstances, a measure of, at least, transitional regulation can be justified. However, once again, the impact of regulation will need to be carefully assessed to ensure that the right balance between efficiency and equity considerations is struck.

Equity goals have been an important component of UK health policy and recent reforms have been accompanied by a re-iteration of commitment to these goals. Despite the creation of an internal market on the delivery side, the equity goal for the NHS remains 'equal treatment for equal need'. Under the pre-reform system, this equity goal, at least as measured in macro data, appears to have been met. The distribution of ill-health is not equal across either income or socio-economic groups. The poor and those in lower socio-economic groups are significantly more likely to report ill-health than those who are better off.[33] However, the distribution of NHS resources, as measured by reported utilisation of NHS facilities in large scale social surveys, is also unevenly distributed. The poor received more health care. If the amount of treatment given is adjusted to reflect the greater morbidity of poorer persons, the distribution across income groups becomes fairly flat. In other words, the pre-reform NHS appears, broadly, to have allocated health care according to need.[34] At present, it is too early to measure the implications for equity of the current quasi-

[31] King's Fund Commission (1992).

[32] Tomlinson (1992).

[33] O'Donnell and Propper (1991).

[34] Propper and Upward (1992).

market system. On the one hand, district health authorities remain responsible for all patients not covered by GP fundholders. While certain patients will cost them more than others, this was also the case under the previous system. As the DHA cannot shed these patients, incentives to provide care for them remain similar to under the previous system.

On the other hand, GP fundholders may have an incentive not to attract patients for whom average costs will be higher than average reimbursement. Such patients will increase their costs more than their revenues and ultimately may threaten their fundholding status. GP fundholders therefore have an incentive to cream-skim; to attract patients who are low risk. A similar phenomenon has been observed in US HMOs.

If cream-skimming occurs, the NHS reforms may lead to the situation where low risk patients get better treatment from GP fundholders, while high risk patients are left in the care of the DHAs, which end up holding a pool of patients, which is ever increasing in the difference between costs and revenues. However, one solution to this potential problem is to set capitation payments to GPs to reflect risk. Setting payments to reflect expected costs reduces incentives for cream-skimming and so reduces incentives which may lead to increased inequity in the distribution of NHS resources.

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1.5 ANALYSIS OF HEALTH CARE POLICY

1.5.1 Current Health Care Policies and Proposals

1.5.1.1 Cost Containment and Micro-Efficiency

Public expenditure controls do work in the UK. Consequently, they offer an extremely effective way of containing NHS expenditure and mean that the UK does not have an aggregate cost containment problem in the same way as do most other OECD countries. However, the shortage of funds and the lack of incentives for economic efficiency mean that rationing takes place in an arbitrary manner creating biased allocation of resources.

The UK health system has had few incentives for encouraging micro-efficiency, and it is this issue that the NHS reforms are designed to address. The basis of the reforms is the introduction of a quasi-market into the NHS, in which the responsibility for purchasing services is separated from the responsibility for providing them. Chart 1.2 identifies the main purchaser and provider agencies.

Most of these have been described earlier in this report, and so only a brief summary is presented here:

- Regional health authorities allocate budgets to DHAs, FHSAs and GP fundholders. At one stage, it looked as if this tier of administration might be abolished. Over time, however, it has become likely that they will remain and carry out regulatory and monitoring functions in relation to district purchasers and/or NHS trusts.

- District health authorities receive annual cash-limited budgets and are responsible for commissioning a range of hospital and community health services for their residents. A number of district purchasers have merged with adjoining ones - or are in the process of doing so - to reap economies of scale.

- Family health authorities have a management responsibility for primary care services. It looks likely that, as more GPs become fundholders, most FHSAs will merge with DHAs to form unified purchasing agencies.

- Non-fundholding GPs provide primary care services and refer patients to specialists. Under the reform arrangements, GPs are normally expected to refer patients to hospitals with whom the patient's DHA has a contract. DoH guidance emphasises that GPs' views need to be taken into account when districts place contracts. The DoH has also stated that GPs should have the option of referrals outside of contracts (in exceptional circumstances) through extra contractual referrals.

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- GP fundholders receive budgets top-sliced from the district's allocation with which they can purchase a designated range of services directly on behalf of their patients.

- Private patients can supplement NHS services from the independent sector or in NHS private patient facilities. Private health insurance has increased rapidly over the last ten years, at least until the economic recession of 1991/2.

- District managed units (DMUs) are those hospitals and other provider units that have not yet acquired trust status and are, therefore, still managed by DHAs. It is intended that this should be a transitional stage and that all providers will eventually become trusts.

- NHS trusts are providers that have been granted self-governing status within the NHS. They are no longer accountable to DHAs, reporting directly to the NHS Management Executive. Trusts are designed to offer greater autonomy to managers over such matters as capital planning and employment policies.

- Private hospitals offer services to private patients, but they are also able to compete for NHS contracts. So far, few of these have been awarded. However, there are a number of examples of joint DHA/independent sector collaboration, such as the joint running of day case units.

1.5.1.2 From Curative to Preventative Medicine

For many years, it has been the conventional wisdom that the NHS is not primarily a 'health' service, but a 'sickness' service; that is, it emphasises curative, rather than preventative, care. Despite much rhetoric emphasising the importance of prevention and health promotion, the sums of money spent on this activity within the typical health authority have been minute compared with the mass of hospital spending. To a large extent, this reflects the powerful service-led interests within most health authorities - particularly that emanating from the high status enjoyed by hospital consultants, many of whom are frankly dismissive of health promotion and public health issues.

The separation of purchasing from provider responsibilities offers the opportunity to redress this imbalance. Purchasers now hold budgets and public health specialists are important members of purchasing teams. Health promotion departments are usually located in, or have a close working relationship with, public health departments. At the same time, the government has signalled its intention of according a high priority to health promotion through the publication of the White Paper, The Health of the Nation.[35]

[35] Department of Health (1992a).

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This White Paper represents a major policy initiative for the UK government, albeit one that the World Health Organisation adopted ten years ago. The strategy outlined in the paper involves identifying particular diseases/causes of morbidity and premature mortality; setting measurable targets for improvement; and, establishing mechanisms for measuring progress towards these targets. The five areas targeted in the White Paper are coronary heart disease (CHD) and stroke, cancers, mental illness, HIV/AIDS and sexually transmitted diseases and accidents.

The approach in the case of CHD and stroke, for example, includes the target:

> "to reduce death rates for both CHD and stroke in people under 65 by at least 40 percent by the year 2000 (from 58 per 100,000 population in 1990 to no more than 35 per 100,000 for CHD, and from 12.5 per 100,000 population in 1990 to no more than 7.5 per 100,000 for stroke)."

Strategies for achieving this target in terms of reductions in the prevalence of smoking, healthier eating standards and physical activity are also specified in quantitative terms.

It should be pointed out that many economists have been critical of the Health of the Nation approach. These criticisms arise because it is not clear how the priority areas or targets were chosen. There is little indication that the relevant costs and benefits of achieving different degrees of health improvement in the different areas were considered. Without this analysis, it is impossible to establish whether these particular priorities will make the most efficient use of scarce resources.

1.5.1.3 Shifts in the Use of Medical Technology

Because of its relatively low expenditure levels on health care, the UK has not witnessed the proliferation of new medical technologies as have some other countries. In 1984, for example, Aaron and Schwartz (1984) pointed out that in comparison with the UK, the United States carried out twice as many X-ray examinations per person; offered more than three times the rate of kidney dialysis treatment; had six times the CT scanning capacity; performed ten times the rate of coronary artery surgery; and, had between five and ten times as many hospital intensive care beds per capita.

Nonetheless, despite the absence of widespread high technology medicine, there has been an increase in the use of new technologies in the UK over the last ten years. In particular, medical advances using minimally invasive diagnosis and treatment have allowed the extension of day case work and led to shorter lengths of in-patient stay (the average length of acute, in-patient stay fell from 9.8 to 6.3 days between 1978 and 1989), while the number of day cases more than doubled over the same period. For similar reasons, more and more patients are able to be treated in their own homes, rather than in hospital settings, giving rise to the term "hospital at home".

1.5.2 Assessment of Current Health Care Policies and Proposals

The reforms which were introduced on 1 April 1991 represent a major change for the NHS. The separation of responsibility for purchasing health care from providing is intended to make services demand-led, rather than supply or service-led as in the past. The internal market is designed to increase productive efficiency among providers through supply-side competition. The devolution of greater power and management autonomy to NHS trusts is also designed to increase productive efficiency. Greater freedom and responsibility is expected to improve performance and lead to greater responsiveness to patients' wishes among GP fundholders.

At the moment, however, these are all largely *a priori* expectations. There is little empirical evidence in terms of which the early performance of the new system can be assessed. Consequently it is not at present easy to see what further reforms will become desirable.

There are a number of unresolved issues that remain and some aspects of the current system still look questionable in terms of their effects on efficiency, equity and choice. These include:

- the lack of financial or competitive incentives for NHS purchasers to increase their efficiency;
- the small size of purchasing agencies;
- the narrow choice of hospitals open to individual NHS patients and their GPs;
- the limited contestability in the hospital sector;
- the lack of an agreed approach to priorities in the NHS (for use when waiting lists become intolerable because the State is unwilling to fund expanding demand); and
- the lack of profit signals within the NHS 'market' to help allocate resources.

PAPER: **White Paper**: 'Working for Patients; The Health Service; Caring for the 1990s'
(Note: this paper lays out the Governments principles that it will be seeking to incorporate in the 1990 Act)

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AUTHOR: Government

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Chapter 3: Self-Governing Hospitals	(pp22-29)
Chapter 4: Funding Hospital Services	(pp30-38)
Chapter 5: The Work of Hospital Consultants	(pp39-46)

Comment:
This section indicates the principles that will be used to determine the nature of the hospital service into the 1990s. Having established in part 1 the general management of the NHS, part 2 seeks to delegate as much decision-making as possible to the local level.

PART TWO: THE HOSPITAL SERVICE

- Now that general management is established, the Government is taking the next logical steps by delegating as much decision-making as possible to the local level. Hospitals and other management units will be expected to carry more direct responsibility for running their affairs. This has implications for the role of the centre and of Regional and District Health Authorities (RHAs and DHAs). It means giving hospitals greater control over, and better information about, their use of resources. (Chapter 2.)

- Hospitals will be able to opt for a new self-governing status while remaining in the NHS. Major acute hospitals are the obvious candidates but others may become self-governing in due course. (Chapter 3.)

- At the same time, the Government wants to create more incentives to better performance by changing the way in which hospitals are funded. At present, hospitals which offer the best value for money are often not rewarded for doing so. Indeed, hospitals may be penalised for their efficiency if they succeed in treating more patients than they had budgeted for. The Government intends to reverse this situation by ensuring that money flows to those hospitals which treat most patients. (Chapter 4.)

- Delegation downwards must be matched by accountability upwards. General managers are already formally accountable for the spending of their health authorities, but it is hospital consultants whose decisions in practice determine how a hospital's resources are used. It is therefore important to ensure that consultants are given more responsibility for their use of resources. (Chapter 5.)

CHAPTER 2 :

MANAGING THE SERVICE

INTRODUCTION

2.1 Since taking office, much of the Government's policy has been aimed at strengthening the management of the hospital service and improving its performance through the better use of resources. These changes have helped to improve efficiency throughout the hospital service, and to generate additional revenue from cash-releasing cost improvements amounting to over £900 million a year by 1988-89. In addition, receipts from land sales should exceed £300 million this year.

2.2 The running of the hospital service cannot however be administered in detail from Whitehall by Ministers or by civil servants. The Government's main task must be to set a national framework of objectives and priorities. Local management must then be allowed to get on with the task of managing, while remaining accountable to the centre for its delivery of the Government's objectives.

DELEGATING RESPONSIBILITY

Central management of the NHS

2.3 The NHS will continue to be funded by the Government mainly from tax revenues. Ministers must be accountable to Parliament and to the public for the spending of these huge sums of money. Such accountability does not mean that Ministers should be involved in operational decisions. On the contrary, these decisions must be taken locally by operational units with Ministers being responsible for policy and strategy.

2.4 The central management of the NHS must reflect this division of responsibilities. The Government proposes that responsibility for strategy will be for an NHS Policy Board chaired by the Secretary of State for Health. Responsibility for all operational matters will be for an NHS Management Executive chaired by a Chief Executive. The Management Executive will be accountable to the Policy Board for the management of the NHS within the strategy and objectives set by the Policy Board.

2.5 The specific proposals are:

- a new NHS Policy Board, chaired and appointed by the Secretary of State, will determine the strategy, objectives and finances of the NHS in the light of Government policy, and will set objectives for the NHS Management Executive and monitor whether they are satisfactorily achieved. It will replace the former Health Service Supervisory Board and will include non-executive members drawn from inside and outside the NHS.

- The NHS Management Executive will be chaired by the Chief Executive and appointed by the Secretary of State in consultation with the Chief Executive. It will deal with all operational matters within the strategy and objectives set by the Policy Board.

- Responsibility for the management of family practitioner services will be brought under the NHS Management Executive. The better integration of primary care and hospital services is an important objective.

2.6 The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

The role of Regions

2.7 The NHS Management Executive could not directly exercise effective authority over the current 190 District Health Authorities (DHAs). Regional Health Authorities (RHAs) will therefore continue to ensure that Government policies are properly carried out within their Regions. To be effective, they will need to concentrate their efforts on their essential tasks. These include setting performance criteria, monitoring the performance of the Health Service and evaluating its effectiveness. They will have a key role to play in managing the wider programme of changes that are set out in this White Paper.

2.8 In addition, RHAs have traditionally provided a range of operational and management services. These include distribution centres, ambulance services and blood transfusion services which could not be provided economically in every District. They also include legal, information and management services to Districts themselves. Following the introduction of general management and the re-organisation of Regional headquarters, many RHAs have reviewed the provision of these services. As a result, some services have already been streamlined, delegated to Districts or contracted out to the private sector.

2.9 There remains, however, a wide variation in the size of each Region's operations. The Government believes that there is still considerable scope for reductions in the number of staff directly employed by RHAs on these operations. The NHS Management Executive will therefore review the provision of all regionally managed services. It will approve the retention of services at the Regional level only if it is cost-effective to do so. As part of this exercise, Districts will be asked whether they can provide more of these services themselves or purchase them from the private sector.

The role of Districts and hospitals

2.10 The Government also believes that there is further scope for delegating decision-making from DHAs to hospitals and their associated management units. Many large hospitals already have a significant degree of self-determination. RHAs will be expected to satisfy themselves that, wherever possible, all DHAs delegate operational functions to their hospitals, taking account of the availability of staff in key disciplines and the need to ensure that, overall, the management of services remains cost-effective.

2.11 The Government's objective is to create an organisation in which those who are actually providing the services are also responsible for day-to-day decisions about operational matters. Like RHAs, DHAs can then concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a comprehensive range of high quality, value for money services; and on setting targets for and monitoring the performance of those management units for which they continue to have responsibility. The Government will expect authorities to provide themselves with the medical and nursing advice they will need if they are to undertake these tasks effectively.

MANAGING RESOURCES

Better use of staff

2.12 One of the keys to successful management of the NHS is good management of people. Chapter 5 includes proposals for ensuring that consultants are involved in the management of hospitals and are given responsibility for the use of resources. But it is nurses who represent the largest single group of professional staff in the NHS and who are responsible for delivering direct patient care around the clock.

2.13 There have been many developments in recent years in the better use of nursing staff, but the Government believes that there is still scope for more progress at local level. It has already endorsed the need to provide better training for the non-professional support staff to nurses. As part of this initiative, local managers, in consultation with their professional colleagues, will be expected to re-examine all areas of work to identify the most cost-effective use of professional skills. This may involve a reappraisal of traditional patterns and practices. Examples include the extended role of nurses to cover specific duties normally undertaken by junior doctors in areas of high technology care and in casualty departments; the use of clerical rather than nursing staff in receptionist work; and making full use of midwives as recommended in the reports of the Maternity Services Advisory Committee. There is also scope for more cost-effective working in other professions, some of which, such as physiotherapists, speech therapists and chiropodists, make little use of non-professional helpers.

Better information

2.14 The Government recognises that managers and professional staff need better information if they are to make the best use of the resources that are available to them. The NHS has made considerable progress in developing better information systems in hospitals, but there remain some important limitations. In particular, there is at present only a limited capacity to link information about the diagnosis of patients and the cost of treatment. The Government believes that the best way to remedy this is by extending and accelerating the existing Resource Management Initiative (RMI). This is intended to provide a complete picture of the resources used in treating hospital patients. A key feature of the RMI is that doctors, nurses and other professional staff have much more information at their fingertips about the care their patients are getting. Their involvement in the development of the RMI has also ensured that the new systems are actively used for the benefit of patients.

2.15 In order to encourage further the involvement of doctors and nurses in management, the Government proposes to implement the RMI programme in England in two stages:

- during 1989, to extend preparation for the RMI in up to 50 acute hospital units, linked to improvements in the coding of medical records and experimentation in analysing activity data into case-mix groups. This stage is aimed at producing activity data that can be used, for example, for medical audit purposes.

- starting late in 1989, to extend the full RMI process to 20 acute hospital units with the aim of building up coverage to 260 acute units by the end of 1991-92.

2.16 This is an ambitious timetable, but the Government remains committed to introducing modern information systems to support both clinical and operational functions in hospitals.

Pay flexibility

2.17 In addition to giving managers the tools with which to manage, the Government wants to give them greater control over the resources for which they are responsible. Pay accounts for over 70 per cent of all NHS expenditure. Getting pay wrong can have serious effects on expenditure on the one hand, and on the availability of staff on the other.

2.18 Chapter 3 proposes that NHS Hospital Trusts should be free to settle the pay of their staff. But the Government's objective throughout the Service is progressively to introduce greater flexibility, in order to allow managers to relate pay rates to local labour markets and to reward individual performance.

2.19 Until recently, there has been no geographical variation of pay (other than London weighting) for NHS staff. The Nurses Pay Review Body, in its 1988 report, recommended London supplements to be paid in addition to London weighting to nurses and the professions allied to medicine, and these were introduced from 1 April 1988. The Government has now asked the Review Body to accept the case for more local discretionary payments to nurses to help with particular local staff shortages and nurse management problems.

2.20 The performance pay arrangements which apply to general managers and other top managers are being extended to senior and middle managers lower down the scale. The extended arrangements, unlike the original ones, include an explicit local flexibility element for posts at these levels, so that managers can react to local recruitment problems.

2.21 Negotiations are already under way to introduce flexibility into the administrative and clerical pay scales. This will be based on a national pay spine, but will allow local discretion to take account of market conditions.

Conditions of service

2.22 The Government also wants to give local managers greater flexibility to determine the conditions of service of NHS staff. This will enable them

to devise employment packages that are most suited to local needs. At present, conditions of service are determined mainly by national negotiations in the Whitley Councils. An internal review of conditions of service by the Department of Health is nearing completion.

Capital

2.23 Managers should also be able to make the most efficient use of their physical resources. Capital in the NHS has been treated for the most part as a "free good". Once an investment has been made, whether in land, buildings or equipment, no further revenue charges arise from the continuing use of these capital assets. This can lead to inefficiency such as the under-utilisation of assets, and may also mean that capital costs are not fully taken into account when, for example, comparisons of cost and performance are made between different parts of the NHS, or with the private sector.

2.24 The Government proposes to introduce a new system of charging for capital in the NHS. From April 1991, health authorities will be charged for the use of their existing capital assets and any new capital investment. The charges will be set to cover the costs of interest and depreciation. Revenue allocations from Regions to Districts will be increased to cover the initial cost of the charges. Future capital investment will incur additional charges. The capital charging and funding system will be designed so that there is no net increase in public expenditure in the NHS and no reductions in the funds available for patient services. The charging system will provide a strong incentive for every authority to use its assets efficiently and to invest wisely. It will also place NHS hospitals on a more level footing with private hospitals, which have to meet the costs of capital on a normal, commercial basis. The Secretary of State will publish shortly a working paper which will set out the detail of how the capital charging scheme will be implemented, as a basis for discussion with interested parties.

2.25 Funds for capital investment will continue to be financed by the Exchequer and , except for NHS Hospital Trusts, will be allocated by RHAs from within an overall capital programme. There will therefore continue to be strategic oversight of capital planning, within an overall cash limit. But the capital charging scheme will ensure that managers are given clear financial signals when taking decisions on capital deployment.

2.26 There are opportunities for health authorities to derive income and large capital sums from property which is surplus to requirements. There is little experience in the NHS of undertaking complex and specialised property transactions. Indeed, health authorities may only encounter this occasionally. In order to assist them in this, the NHS will in future be able to call on the advice of a central group of professionals, including members drawn from the private sector with the necessary property, financial and legal expertise.

2.27 The Government also intends to delegate more decisions about individual capital schemes. The expenditure limits above which projects have to be referred centrally for approval will therefore be increased. From now on only schemes with a capital cost of over £10m (previously £5m) will be referred to the Department of Health for approval. Of these, only those over £15m (previously £10m) will be referred to the Treasury. These increases will be a welcome step forward in speeding up investment approvals and giving health service managers greater freedom over key resource decisions.

Private capital

2.28 As health authorities become more business-like in their approach to the provision of services, and to the use of the resources at their disposal, they are increasingly looking at the scope for involving the private sector. Examples include joint ventures where the NHS provides land and a developer puts up a building, or where a major service is contracted out to the private sector. There may also be opportunities for an authority to work with a private developer to achieve a net saving. The Government is determined to encourage these schemes whenever they are consistent with value for money and the proper control of public expenditure.

INDEPENDENT AUDIT

2.29 To assist in the aim of achieving better value for money, the Government intends also to make changes in the arrangements for audit. At present, the statutory external audit of the accounts of the health authorities and Family Practitioner Committees (FPCs) is carried out by the Health Departments. The Government's objective is that there should be more commitment to value for money studies, which would cover a wider range of NHS activity, by an audit body that is demonstrably independent of the health authorities and FPCs, and of the Health Departments.

2.30 Accordingly, the Government proposes to transfer responsibility for the statutory external audit in England and Wales to an independent body, the Audit Commission. The Audit Commission is currently responsible for the audit of local authorities in England and Wales; these audits are carried out by a mixture of the Commission's own staff and private sector firms. The Commission has considerable experience and expertise in areas of work closely related to the Health Service. In particular, it is accustomed to working in multi-disciplinary teams with professionals looking at the professional aspects of services. This will mean the involvement of independent professionals in audit work and will be an important part of the Commission's new role in the Health Service.

2.31 The Local Government and Housing Bill to be published soon after this White Paper will include a provision which will enable the Audit Commission to undertake audit in the NHS under authority of the Secretary of State. This will develop the experience of the Audit Commission, and enable its staff to start to work with the officials in the Department of Health and Welsh Office who are currently responsible for NHS audit. The Government intends to bring forward further legislation formally establishing the Audit Commission as the body responsible for the external audit of health authorities and other NHS bodies in England and Wales which are at present audited by the Department of Health and the Welsh Office. In this capacity, it would report to the appropriate Secretary of State. It is also likely that the bulk of the staff of the present NHS statutory audit service, who are civil servants and employees of the Department of Health and Welsh Office, will transfer to the Audit Commission. In this way there will be continuity of expertise in the audit of the NHS.

2.32 The responsibilities of the Audit Commission will cover the full range of organisations within the NHS as they develop, including the proposed NHS Hospital Trusts and GP practice budgets. It will provide an independent source of advice to Ministers. Its reports will be published under the authority of the Secretaries of State for Health and for Wales, and will be made available to Parliament and the public.

2.33 The role of the National Audit Office will remain unchanged. As an Officer of Parliament, the Comptroller and Auditor General will continue to report on value for money in the use of voted funds, and to certify the aggregated accounts of the NHS, drawing upon the audits carried out by the Audit Commission, just as at present he draws upon the audits carried out by the Health Departments.

CHAPTER 3 :

SELF-GOVERNING HOSPITALS

INTRODUCTION

3.1 This chapter sets out the Government's proposals for enabling as many hospitals as are willing and able to do so to run their own affairs, whilst remaining in the NHS.

3.2 The Government expects that major acute hospitals will be the most suitable candidates for its proposals, but other hospitals may also come within their scope. There are currently over 320 major acute hospitals in the UK - "major" defined as having more than 250 beds. These are substantial enterprises. Even the smallest of the management units which currently run these hospitals may have revenue budgets in excess of £10 million a year. The largest may have budgets in excess of £50 million. Some of these hospitals already have substantial responsibilities delegated to them for running their own affairs. The Government intends to take this process much further by providing for a full, self-governing status for hospitals.

3.3 The Government believes that self-government for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals can flourish, it will encourage local initiative and greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered.

NHS HOSPITAL TRUSTS

3.4 The powers and responsibilities of each self-governing hospital will need to be formally vested in a new and separate legal body, to be known as an NHS Hospital Trust. Each NHS Hospital Trust will be run by a board of directors. The Government will bring forward legislation enabling the Secretary of State to establish NHS Hospital Trusts and to appoint their boards. The Government proposes that the board of directors of an NHS Hospital Trust should be constituted as follows:

- There will be a balanced number of executive and non-executive directors and, in addition, a non-executive chairman.
- No board will have more than ten directors, excluding the chairman.
- The chairman will be appointed by the Secretary of State.
- Of the non-executive directors at least two will be drawn from the local community, for example from hospital Leagues of Friends and similar organisations. These two "community" directors will be appointed by the Regional Health Authority (RHA). The remaining non-executive directors will be appointed by the Secretary of State after consulting the chairman. All the non-executive directors will be chosen for the contribution they personally can make to the effective management of the hospital and not for any interest group which they might represent. None will be an employee of a health authority or hospital, of a trade union with members who work in the NHS, or of a major contractor or other hospital supplier. For teaching hospitals, the non-executive directors will need to include someone drawn from the relevant medical school.
- The executive directors will include the general manager of the hospital, a medical director, the senior nurse manager and a finance director. They will be full members of the board. The general manager will be appointed by the non-executive directors, and the other executive directors by the non-executive directors acting with the general manager.

3.5 NHS Hospital Trusts will be empowered by statute to employ staff; to enter into contracts both to provide services and to buy in services and supplies from others; and to raise income within the scope set by the Health and Medicines Act 1988.

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FUNDING

An NHS Hospital Trust will earn its revenue from the services it provides. The main source of revenue will be from contracts with health authorities for the provision of services to their residents. Other contracts and revenue will come from GP practices with their own NHS budgets, private patients or their insurance companies, private hospitals, employers and, perhaps, other NHS Hospital Trusts. This form of funding will be a stimulus to better performance. There will be an opportunity to finance improved and expanded services because the money will flow to where the patients are going. Hospitals which prove more popular with GPs and patients will attract a larger share of NHS and other resources available for hospital services. A successful hospital will then be able to invest in providing still more and better services.

3.7 Contracts will need to spell out clearly what is required of each hospital in terms of the price, quality and nature of service to be provided. A hospital which fails to meet the terms of a contract will risk losing patients and revenue. The arrangements set out in chapter 4 will ensure that patients who are in need of urgent treatment are not turned away from a hospital simply because their treatment is not, or may not be, covered by a contract with that hospital. Of course there will be no question of patients who need urgent treatment being denied it.

3.8 Health authority funding will continue to be cash-limited, and this will place authorities under a strong incentive to secure value for money through their contracts. Performance-related contracts of employment will similarly provide strong incentives for hospital managers to improve the quantity and quality of the services on offer. Competition with other hospitals, where it is effective, should also constrain costs.

3.9 Each Health Department's Accounting Officer will have an overall responsibility for the stewardship of public funds by NHS Hospital Trusts. The Secretary of State will need specific powers for use in reserve to prevent any NHS Hospital Trust with anything near to a local monopoly of service provision from exploiting its position, for example by charging unreasonably high prices for its services.

FREEDOM AND RESPONSIBILITY

3.10 The Government proposes to give NHS Hospital Trusts a range of powers and freedoms which are not, and will not be, available to health authorities generally. Greater freedom will stimulate greater enterprise and commitment, which will in turn improve services for patients. NHS Hospital Trusts will be a novel part of a system of hospital care alongside health authority-managed and private sector hospitals, and will increase the range of choice available to patients and their GPs.

Employment of staff

3.11 The Government intends that NHS Hospital Trusts should be free to employ whatever and however many staff they consider necessary, except that junior doctors' posts will continue to need the approval of the relevant Royal College for training purposes. The Government sees it as particularly important that Trusts should employ their own consultants. Where consultants also work for other NHS hospitals or in the private sector, a Trust will need to employ them on a part-time basis consistent with their commitment to the Trust's hospital.

3.12 The Government also intends that NHS Hospital Trusts should be free to settle the pay and conditions of their staff, including doctors, nurses and others covered by national pay review bodies. Subject to their contractual obligations, NHS Hospital Trusts will be free either to continue to follow national pay agreements or to adopt partly or wholly different arrangements.

Ownership of assets

3.13 NHS Hospital Trusts will be constituted as public corporations. Each hospital's assets will be vested in its Trust, as follows:

- The Trust will be free to use the hospital's assets to provide health care, in accordance with stated purposes laid down by the Secretary of State when self-governing status is granted.

- The Trust will be free to dispose of its assets, subject only to a reserve power for the Secretary of State to intervene if a disposal would be against the public interest.

- When it is established, the Trust will be given an interest-bearing debt equal to the value of its initial assets. The effect of these and other arrangements for servicing capital will be consistent with that of the new capital charging system proposed for NHS hospitals generally in chapter 2.

- The Trust will be free to retain surpluses and to build up reserves with which to improve services and finance investment. It will also be free to manage any temporary deficits.

- The Trust's operations will be subject to independent audit by the Audit Commission in accordance with the proposals in chapter 2. The National Audit Office will have right of access to papers relating to the accounts and audit of NHS Hospital Trusts, and will be able to include them in their value for money studies.

- The hospital's assets will revert to the ownership of the Secretary of State if for any reason the Trust is wound up.

Borrowing powers

3.14 NHS Hospital Trusts will be free to borrow, either from the Government or from the private sector, subject to an overall annual financing limit. The Government will seek limited reserve powers for the Secretary of State to use if this freedom is being abused or if a Trust is getting into difficulties. The annual financing limit will be set each year by the Secretary of State following the Government's Public Expenditure Survey. Borrowing from the Government will be from funds voted by Parliament. NHS Hospital Trusts will have to service their loans from their income, just as other NHS hospitals will be charged for their capital.

ACHIEVING SELF-GOVERNMENT

3.15 The Government will lay down a simple, flexible process for establishing an NHS Hospital Trust. It will be open to a variety of interests either to initiate the process or to respond to any initiative taken by the Secretary of State. These interests could include the District Health Authority (DHA), the hospital management team, a group of staff, or people from the local community who are active in the hospital's support.

3.16 The Government is not proposing a rigid definition of what a "hospital" should be for the purposes of self-government. For example, it will often be sensible for a hospital to retain its existing obligations to run a range of community-based services. Similarly, neighbouring hospitals may want to combine into a single management unit.

3.17 Hospitals will have to meet only a few essential conditions to achieve self-governing status. There will be two main criteria. First, management must have demonstrated the skills and capacity to run the hospital, including strong and effective leadership, sufficient financial and personnel management expertise and adequate information systems. Second, senior professional staff, especially consultants, must be involved in the management of the hospital. The Secretary of State will need to satisfy himself that self-governing status is not simply being sought as an alternative to an unpalatable but necessary closure. The NHS must not be obliged to retain hospitals which are redundant to its needs.

3.18 The Government will look to RHAs to play an active part in guiding and supporting hospitals which can be expected to meet these criteria and are interested in achieving self-government. In each case, the Secretary of State will need to satisfy himself at an early stage that there is a good prospect of being able to approve the creation of a new NHS Hospital

Trust. With the advice of the RHA, he will also need to identify a "shadow" chairman who can act for the hospital in preparing the ground.

3.19 NHS Hospital Trusts must also continue to provide essential core services to the local population, including accident and emergency facilities, where no alternative provision exists. RHAs will need to ensure that this is so when submitting and advising on a formal application to the Secretary of State. They will also need to ensure that the proposal to seek self-governing status is given adequate publicity locally.

3.20 The establishment of NHS Hospital Trusts will mean a substantial change in the responsibilities of the DHAs which were previously responsible for their management. As more and more proposals for establishing NHS Hospital Trusts come forward, RHAs will need to consider the viability of existing DHAs and the possibility of sensible mergers with neighbouring Districts. Larger Districts might eventually become candidates for mergers with Family Practitioner Committees.

IMPLEMENTATION

3.21 The Government believes that NHS Hospital Trusts have a major role to play in improving services to patients. It will therefore encourage as many major acute hospitals as possible to seek self-governing status. The Government's aim is to establish a substantial number of Trusts with effect from April 1991, in the wake of the necessary legislation. The experience gained will then inform the process of establishing more Trusts in later years. The Secretary of State will be issuing shortly a working paper which will set out in more detail the scope of self-governing status and proposals for implementing it, as a basis for discussion with interested parties.

3.22 The Government and RHAs will identify suitable early candidates for self-government and encourage them to seek and prepare for self-governing status. The aim will be to ensure that the hospitals concerned make productive use of the next two years by building up their capacity to run their own affairs effectively and by securing the maximum devolution of management responsibility from their DHAs. Self-government will then be - as it should be - a natural step forward from devolved management within the present structure.

CHAPTER 4 :

FUNDING HOSPITAL SERVICES

INTRODUCTION

4.1 Hospital services must be funded in a way which encourages more choice and more value for money.

4.2 Chapters 2 and 3 of this White Paper set out the Government's proposals for delegating to hospitals themselves the main, operational responsibility for providing hospital services. At the moment, District Health Authorities (DHAs) provide those services and are funded to do so. The Government believes that the primary task of each DHA should be to secure the best and most cost-effective services it can for its patients, whether or not those services are provided by the District's own hospitals. This in turn implies that health authorities should be funded for the population they serve, and not for the services they provide.

4.3 Similarly, the Government believes that NHS hospitals should be free to offer their services to their own Districts and to other Districts in a way which enables them to attract the funds they need in line with the work they are asked to do. This means that hospitals should be funded more directly for the volume and quality of the services they provide. At present, a hospital which becomes more efficient and could treat more patients may be prevented from doing so by the budget imposed on it. Another, which is doing less work and operating at lower levels of efficiency, may still be funded at the same level. The Government is determined to change this by making it possible for the money available to treat patients to move more freely to the hospitals which offer patients the best service and the best value for money.

FUNDING HEALTH AUTHORITIES

The present system

4.4 Since 1977, money has been allocated to Regional Health Authorities (RHAs) on the basis of a formula which seeks to identify the health care needs of each Region's population. The formula is known as RAWP (Resource Allocation Working Party). Each year, when making financial allocations to Regions, the Government decides how far actual allocations should move towards the target shares indicated by the formula. When the formula was introduced Regions were on average over eight per cent away from their RAWP targets, with a range from 11 per cent below to 15 per cent above. Now 11 of the 14 are within three per cent.

4.5 RHAs tend to vary in the extent to which they rely on the RAWP formula when allocating funds to Districts. In recent years, growth money has usually been allocated on the basis of planned service developments - for example, to enable a new hospital to open - rather than by a simple application of the formula.

4.6 The undesirable result of the present system is that there is no direct relationship between the amount of money a District is allocated and the number of patients its hospitals are treating. This is partly because the movement of patients across Regional boundaries is reflected only retrospectively in the formula, and because the resulting changes affect only target, not actual, allocations. Allocations to Districts also reflect historical patterns of service use and pay insufficient regard to varying levels of efficiency and performance. This confusing pattern is often the cause of local financial problems within a service whose total resources have been rising rapidly.

A new approach

4.7 The Government proposes to simplify and improve the arrangements for allocating funds to RHAs and DHAs. The underlying principles to be applied are the same in both cases. The Government recognises the need for a transitional period, which will be longer at District than at Regional level.

Allocations to RHAs

4.8 RHAs will be funded on a capitation basis, weighted to reflect the health and age distribution of the population, including the number of elderly people, and the relative costs of providing services. The Thames Regions will receive a slightly higher level of funding than the rest - some three

per cent higher per head of population - to reflect the higher costs of and demands on services in the capital in particular. The Government aims to move to this new system over a two year period, starting in April 1990. There will be no separate "targets": the change to weighted capitation will bring actual allocations into line with a revised and simplified basis of funding.

4.9 From April 1990 allocations will be based on each Region's resident population. Regions will then pay each other directly, and therefore more quickly and in full, for the work they do for other Regions - so-called "cross-boundary flows". RHAs will be asked to agree the cost of these flows so that direct payment can start in 1990-91, initially by agreed cash limit adjustments until the Government has obtained the powers needed to enable health authorities to charge each other.

4.10 The arrangements described in paragraphs 4.8-4.9 will replace the use of the RAWP formula. The RAWP system has proved a useful method of producing a better distribution of resources nationally. But the Government has applied it over the years to such effect that the major differences have gone and it is no longer necessary. It would steadily become an academic exercise to try to get all Regions ever closer to complicated, ever-changing targets. The Government intends to move on from RAWP to a simpler and more predictable approach. Weighted capitation will be a fair and easy to understand system for providing health authorities with the means to buy the best possible service for patients in every part of the country.

Allocations to DHAs

4.11 At present Districts are funded mainly according to where hospitals happen to be located. In future, like Regions, they will be funded for their resident populations. Districts will pay directly for the services provided for their patients by hospitals in other Districts. The transition will take longer than at Regional level, and will depend on improving local information about population, the movement of patients and the costs of different treatments. The Government expects some DHAs to be in a position to pay each other directly from April 1991. Other authorities, drawing on the experience gained, will be expected to follow suit in the next year.

4.12 Even after adjusting for cross-boundary flows, there are significant differences between current District allocations and an approach based on weighted capitation. Residents in Districts with more hospital services tend to use them more than people with fewer local facilities. Differences in the quality of general practice or community-based services locally can also affect the use of hospital services and their cost. Districts will in due course be funded on broadly the same basis as Regions, but the Government recognises that to do so to the same timetable would in some cases involve sudden and substantial changes in the money available to buy services for each population. Such changes must be carefully managed over a transitional period as the overall level of resources grows. The Government will discuss with RHAs the detailed implementation of these proposals.

FUNDING HOSPITAL SERVICES

4.13 The present system of funding offers only limited incentives for hospitals to satisfy the needs and preferences of patients or to take on additional work by improving productivity. In future, each DHA's duty will be to buy the best service it can from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Hospitals for their part will have to satisfy Districts that they are delivering the best and most efficient service. They will be free to offer their services to different health authorities.

4.14 The following paragraphs outline how this approach will work. The Secretary of State for Health will publish shortly a working paper which will set out the detail of how the changes required will be implemented, as a basis for discussion with interested parties.

"Core" services

4.15 There are many services to which patients need guaranteed local access. These "core" services can be divided into five broad categories:

- accident and emergency (A and E) departments;
- immediate admissions to hospital from an A and E department, including a significant proportion of general surgery;
- other immediate admissions, such as most general medicine and many hospital geriatric and psychiatric services;
- out-patient and other support services which are needed in support of the first three categories, either on site or immediately available;
- public health, community-based services and other hospital services which need to be provided on a local basis, either as a matter of policy - for example, services for elderly or mentally ill people - or on grounds of practicability - for example, district nursing and health visiting.

4.16 Where core services are provided by a hospital which continues to be managed directly by its DHA, they will be funded through a management budget. Management budgets will enable DHAs to set clear targets for the quantity and quality of the hospital's services, and to assess the hospital's performance against these targets. As better cost information becomes available, Districts will be able to refine and improve their target-setting and monitoring.

4.17 Alternatively, it will be possible for all or some of these core services to be bought by a District from an NHS Hospital Trust, or from a directly managed hospital in a neighbouring District, under an annually negotiated contract. Under this arrangement, hospitals will provide an agreed range of services, for a fixed payment, to all patients from the buying District who are referred or admitted.

4.18 The emergency services provided by a hospital will of course always be available immediately, without any question as to where the money is coming from. The Government will develop and implement its proposals in a way which ensures that the costs of emergency services and those requiring immediate admission to hospital can be met for every patient who needs them, irrespective of whether the patient is resident in a District which has a contract with the hospital.

Other services

4.19 Where patients and their GPs have time to choose when and where to seek hospital treatment, Districts will be able to buy services in a more flexible way. There are broadly three categories of such services:

- those which most Districts provide but for which patients may be prepared to travel if a better service is available elsewhere. These are mainly surgical operations, such as hernias and hip replacements, which make up the bulk of waiting lists.
- those not provided in every District, such as ear, nose and throat (ENT), ophthalmology and oral surgery;
- other services for which patients may wish to choose the location, for example some long-stay care for elderly people.

4.20 Most of these services will be provided under a contract which specifies a minimum and maximum number of cases to be treated. An initial payment would cover the minimum volume of work, with extra cases paid for as they arise, up to the specified maximum. The minimum payment assures the hospital of a contribution towards its fixed costs. This arrangement will apply to most in-patient and day case treatment within the services described in paragraph 4.19.

4.21 DHAs will want to keep a relatively small sum for buying services case by case, at a price quoted by a hospital. This opens up the scope for buying services at marginal cost as hospitals seek to use any spare capacity.

4.22 DHAs will be expected to use these new arrangements to offer more choice to patients. The range of choice available locally will depend in

part on the accessibility of different hospitals. Districts will be free to buy from the private sector as well as from other Districts and from NHS Hospital Trusts.

4.23 Offering choice to patients means involving GPs far more in key decisions. When they place contracts, DHAs will need to take account of the existing referral patterns of GPs who have patients resident in their Districts. They will need to discuss with GPs the possibility of changing those patterns where they believe that better value for money can be obtained by doing so. GPs for their part will want to make sure that their views on the quality of care and shorter waiting times are reflected in a DHA's contracts. GPs who take part in the practice budget scheme set out in chapter 6 will be taking these decisions for themselves.

4.24 Under the present arrangements, hospitals are increasingly reluctant to accept referrals from GPs for patients who are not local residents, because there is no direct payment for cross-boundary flows. By enabling the patient's own DHA to pay for the services required, the Government's proposals will mean that hospitals accepting referrals from elsewhere will not have to do so at the expense of increasing waiting times for local patients. DHAs will need to allow for referrals by GPs to hospitals with whom no contracts have been placed, keeping some funds in reserve for this purpose.

4.25 For these new arrangements to work to best effect, GPs and their patients will need to be well informed about the choices on offer. The Government is putting further work in hand to help with this. It will improve information for GPs about their referral patterns. Information of this kind will be needed anyway for the practice budget scheme. It will be exploring how best to develop and publish indicators of hospital performance which cover the quality as well as the efficiency of the services provided. Subject to the forthcoming Monopolies and Mergers Commission report on restrictions on doctors' advertising, it will also discuss with the General Medical Council how to make it easier for hospital consultants to give GPs factual information about the services they offer.

4.26 The Government believes that these new funding arrangements will bring down waiting times for hospital treatment. They will move money to where the work is best done, and will make maximum waiting times an important feature of contracts and management budgets. DHAs, and GPs within the practice budget scheme, will seek to buy where waiting times are shortest, and hospitals will have a stronger incentive to reduce their waiting times in order to attract funds. In the meantime, the Government intends to build on the current waiting list initiative. The central waiting list fund will be targeted at Districts which show that they can use the extra money effectively.

Specialist services

4.27 Specialist services can be divided into two broad categories:

- so-called "supra-Regional" services. These are provided from a few, chosen national centres and are funded centrally. They include heart and liver transplants and neo-natal and infant cardiac surgery.

- Regional and "supra-District" services. These are designated by RHAs and may include cardiac surgery for adults, neo-natal intensive care and radiotherapy.

4.28 Most of these services will in future be bought by Districts for their resident patients from their basic allocations. Contracts will cover both direct referrals from the A and E department or GPs and referrals to a specialist consultant from another consultant. Some central funding will be necessary for the development of supra-Regional services, and RHAs may decide to adopt a similar approach to the funding of some Regional and supra-District services. The NHS Management Executive will discuss with RHAs the detailed application to specialist services of the new funding arrangements proposed.

Training and research

4.29 Most hospitals will incur costs which do not arise directly from the treatment of patients. The main examples are medical, nurse and other training; and research. Some of these costs are directly attributable to the

training or research itself. Other costs arise from the impact of training or research needs on service costs.

4.30 The Government is firmly committed to maintaining the quality of medical education and research. It recognises the complexity and special needs of these areas. Health authorities involved in medical education incur additional costs which will continue to be reflected in the new funding arrangements through an improved "service increment for teaching" (SIFT). The Government has set up an inter-departmental Steering Group on Undergraduate Medical and Dental Education to examine the special problems of providing for medical education. The Group will develop its work, and make recommendations in the light of the proposals in this White Paper. The Government will discuss with RHAs and others concerned how best to ensure that other costs associated with training and research are also met without putting one hospital at an unfair disadvantage by comparison with another.

CHAPTER 5

THE WORK OF HOSPITAL CONSULTANTS

INTRODUCTION

5.1 The NHS employs over 48,000 hospital doctors, of whom nearly 17,000 are consultants. The reforms proposed by the Government in this White Paper will make it easier for consultants and their colleagues to get on with the job of treating patients. The greater autonomy for hospitals proposed in chapters 2 and 3 will remove unnecessary central and Regional controls. The new funding arrangements set out in chapter 4 will steer resources to those consultants best able to provide a good quality service and to treat more patients. The expansion of the resource management initiative outlined in chapter 2 will give them budgetary and information systems more sensitively tuned to medical needs.

5.2 The decisions taken by consultants are critical to the way in which the money available for the NHS is used. It is therefore important to ensure that consultants are properly accountable for the consequences of these decisions. This chapter sets out the Government's proposals for striking a proper balance between two legitimate pressures, both of which are focused on patients' interests: the professional responsibilities and rewards of the individual consultant; and the responsibility of managers to ensure that the money available for hospitals buys the best possible service for patients.

MEDICAL AUDIT

5.3 A patient's primary concern, of course, is to be given a correct diagnosis and then to receive the best possible treatment. Within the next two years, the Government would like to see all hospital doctors taking part in what doctors themselves have come to call "medical audit" - a systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient.

5.4 Medical audit is essentially a professional matter. It is a means of ensuring, through peer review of medical practice, that the quality of

medical work meets acceptable standards. It necessarily requires both specialised knowledge of current medical practice and access to adequate medical records.

5.5 Medical audit must be developed and implemented with care. Medicine is an inexact science, often lacking generally accepted measures of the benefits to patients from different techniques and services. Medical audit must not discourage doctors from taking on difficult but essential clinical work.

5.6 The Government welcomes the initiatives which the medical profession is already taking, both nationally and locally, to foster the development of medical audit, and aims to work with the profession to build on what has been achieved. For example, the Secretary of State for Health has asked the statutory Standing Medical Advisory Committee to consider and report on how the quality of medical care can best be improved by means of medical audit, and on the development of indicators of clinical outcome. The Government will also encourage all the Royal Colleges to make participation in medical audit a condition of a hospital unit being allowed to train junior doctors.

5.7 Management too has a responsibility to ensure that medical audit becomes firmly established, especially at local level. The Secretary of State will publish shortly a working paper which will set out the detail of how an effective framework for medical audit might be implemented, as a basis for discussion with interested parties. The Government's aim is to secure such a framework in all NHS hospitals, including self-governing hospitals, by April 1991.

5.8 The Government's approach is based firmly on the principle that the quality of medical work should be reviewed by a doctor's peers, whilst recognising also that management itself is responsible for ensuring that resources are used in the most effective way. The Government's main proposals are as follows:

- Every consultant should participate in a form of medical audit agreed between management and the profession locally.
- The system should be medically led, with a local medical audit advisory committee chaired by a senior clinician.
- District management should be responsible for ensuring that an effective system of medical audit is in place, and also that the work of each medical team is reviewed at whatever regular, frequent intervals are agreed locally.
- Peer review findings in individual cases should be confidential, but the general results of medical audit should be available to management locally and the lessons learned published more widely.
- Management should be able to initiate an independent professional audit, for example where there is cause to question the quality or cost-effectiveness of a service. The possibility of independent doctors working jointly with the Audit Commission is discussed in paragraph 2.30.

5.9 The Government recognises that medical audit needs a significant investment of time by doctors themselves, and adequate support to ensure that the necessary information is available. The Government is confident that this investment will prove worthwhile by further improving the quality of service to NHS patients.

MANAGING THE CONSULTANT'S CONTRACT

5.10 Most hospital services are the responsibility of District Health Authorities (DHAs). But, with the exception of those working in Teaching Districts or for Special Health Authorities, consultants' contracts are held by Regional Health Authorities (RHAs). This has tended to cause confusion about the nature of a consultant's accountability to local management and the DHA. It has also tended to leave unclear what a District can and should expect of its consultants.

5.11 The Government believes that it is unacceptable for local management to have little authority or influence over those who are in practice responsible for committing most of the hospital service's resources. This does not mean moving consultants' contracts from RHAs to DHAs, which would cause unnecessary disruption. The Government proposes instead to ensure that each DHA acts as its RHA's agent in agreeing with consultants the scope and arrangement of their NHS duties in each hospital. NHS Hospital Trusts will employ their own consultants, as proposed in chapter 3.

Job descriptions

5.12 The key to the local management of consultants' contracts is that every consultant should have a fuller job description than is commonly the case at present. This will need to cover their responsibility for the quality of their work, their use of resources, the extent of the services they provide for NHS patients and the time they devote to the NHS. These job descriptions, which will be reviewable annually, will be an essential tool for managing all consultants' contracts. They will need to be sufficiently detailed, for example as to the number of outpatient clinics which a consultant is expected to hold, to enable District management to monitor whether consultants are fulfilling their contractual obligations.

5.13 DHAs will be asked to agree a job description along these lines with each of their consultants. They will need to do so in a way which preserves both the freedom of consultants to take clinical decisions within the boundaries of accepted professional standards and their 24-hour responsibility for their patients. The Government will discuss with management and the medical profession nationally how best to implement this, including a suitable national framework for consultants' job descriptions.

Appointments

5.14 There is currently no provision for District management to take a full and formal part in the appointment of a consultant. Consultant appointments are recommended by mainly professional Advisory Appointment Committees, whose primary consideration is the professional suitability of the candidate. The Government will seek to amend the Appointment of Consultants Regulations to enable District General Managers to take part directly in the appointments procedure. Professional suitability will and should remain essential, but the general manager's presence will help the Committee to take into account a candidate's willingness and ability to meet the requirements of the post for the management of resources and the development of services.

Disciplinary procedures

5.15 The Government intends to complement these changes by improving the present disciplinary procedures for consultants. These procedures are at present cumbersome and inflexible. They have recently been reviewed by a Joint Working Party of the Health Departments and the profession, established by the Government in 1987. The Working Party has made a number of valuable recommendations. The Government will now open negotiations with the profession on the basis of the Working Party's report.

5.16 The Government sets particular store by two of the changes which the Working Party suggests. The first is the introduction of new, local procedures for dealing with circumstances which warrant disciplinary action short of dismissal. The second concerns the right of a consultant dismissed by his employer to appeal to the Secretary of State against his dismissal. This can be a time-consuming and costly process, the prospect of which may deter management from embarking on dismissal proceedings in the first place. The Government therefore welcomes the Working Party's proposal for a timetable which should lead to concluding an appeal within not more than nine months of the dismissal.

REFORM OF DISTINCTION AWARDS

5.17 Some 35 per cent of consultants currently receive of a distinction award. This takes the form of a superannuable increase in salary at one of four levels. There are currently some 3,900 'C' awards (£6,260), 1700 'B'

awards (£14,200), 700 'A' awards (£24,850) and nearly 200 'A+' awards (£33,720) in Great Britain. Distinction awards are intended to reward clinical excellence, and are payable until retirement. The normal pattern is for progression through the levels of awards. New and increased awards are given on the advice of an independent professional committee.

5.18 The distinction awards scheme was introduced in 1948, and has remained substantially unchanged since then. In their 1988 report (Cm 358), the Review Body on Doctors' and Dentists' Remuneration suggested that expenditure on the scheme should result as far as possible in a benefit to the NHS, as well as rewarding doctors for their individual efforts. The Government agrees. It believes that the nature and administration of the scheme should now be changed, with two main objectives in view: to reflect the wider responsibilities of consultants for the effective use of resources, as well as the clinical merit of their work; and to ensure that the scheme offers consultants stronger incentives to maintain and improve their contribution to local services.

5.19 The Government proposes to open discussions with the medical profession nationally with the following changes in mind:

- to modify the criteria for 'C' awards, so that in future consultants must demonstrate not only their clinical skills but also a commitment to the management and development of the service. There will be limited exceptions, to meet the circumstances of consultants whose jobs include only a small management content.

- to restrict progression to the remaining three levels of awards to those consultants who have earned 'C' awards.

- to change the composition of the regional committees which nominate candidates for 'C' awards. In future, each committee will be chaired by the RHA Chairman and will include senior managers as well as clinicians.

- to change the composition of the national Advisory Committee on Distinction Awards, to provide for a stronger management influence on the choice of award holders.

- to make new or increased awards reviewable every five years.

- to make new or increased awards pensionable only if a consultant continues working in the NHS for at least three years. The Government believes that this will meet the criticism made by the Review Body that awards given to those approaching retirement, with the additional pension benefits entailed, can hardly be said to be in the best interests of the Service.

ADDITIONAL CONSULTANTS

5.20 The Government believes that faster progress in reducing waiting times for treatment and in improving the quality of services for NHS patients can be made by the creation of more consultant posts. This would also help to improve the career prospects, and to reduce the working hours, of junior doctors. The Government therefore proposes to introduce a scheme under which 100 additional, permanent consultant posts can be created over the next three years. The cost of these posts will be met over and above the cost of the two per cent annual expansion in consultant numbers already planned. The scheme will concentrate on increasing the number of consultants in those acute specialties which currently have the longest waiting times for treatment.

PAPER: **National Health Service & Community Care Act 1990**

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CONTENTS OF THE 1990 ACT:

Act making provision about health authorities and other bodies, and amending and repealing past laws

Allows establishment of NHS Trusts and GP budget holders; decides direction of health related services offered by local authorities

CONTENTS RELEVANT TO NHS TRUSTS:

PART 1. THE NATIONAL HEALTH SERVICE IN ENGLAND & WALES
Sections 5. - 11. National Health Service Trusts (pp6-13)

SCHEDULES
Schedule 2 - National Health Service trusts (pp77-84)
Schedule 3 - Financial Provisions relating to NHS Trusts (pp84-86)

IMPLICATIONS OF THE RELEVANT SECTIONS:

SECTION 5.
The Secretary of State may establish NHS trusts which
1. assume responsibility for the management of existing hospitals or other facilities previously managed by Regional, District or Special Health Authorities
2. provide hospitals and manage them

SECTION 6.
Staff employed at hospitals become part of and transfer to the NHS trust once it becomes operational

SECTION 7.
Gives supplementary provisions as to the transfer of staff into the NHS trust.

SECTION 8.
The Secretary of State can order the transfer of property, rights and liabilities from the health authority into the NHS trust to enable it to carry out its functions

SECTION 9.
Each NHS trust has an 'Originating Capital Debt' of an amount specified by an order of the Secretary of State. This 'originating capital debt' represents the excess of the valuation of the assets over the amounts of the liabilities on establishment of the NHS trust.

SECTION 10.
Every NHS trust has financial obligations, including that revenue must be sufficient to meet outgoings from the revenue account

SECTION 11.
Through statutory instruments the Secretary of State can make provision for trustees for the NHS trust; the trustees have power to accept, hold and administer

any property on trust for i.the purposes of the NHS trust or ii. for other health service purposes

IMPLICATIONS OF THE RELEVANT SCHEDULES:

SCHEDULE 2.

For orders (statutory instruments) issued under section 5 concerning the establishment of NHS trusts

Part 1.Reference to section 5

Part 2. Specific duties of the NHS trust

(eg, provide healthcare 'effectively, efficiently and economically')

Part 3. Supplementary provisions concerning, for example, re-imbursement for non-NHS work

Part 4. The dissolution of NHS trusts can be achieved on request from the NHS trust or on order of the Secretary of State

SCHEDULE 3.

Financial constraints on the NHS trusts covering:
borrowing, guarantees of borrowing, limits of indebtness, capital injections ('additional public dividend capital'), surplus funds and investment

National Health Service and Community Care Act 1990

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PART 1

SECTIONS 5. - 11.

PART I

(9) In subsection (2) above "NHS trust" includes—

1978 c. 29.

(a) such a trust established under the National Health Service (Scotland) Act 1978; and

(b) a body established in Northern Ireland and specified by an order made by statutory instrument by the Secretary of State as equivalent to an NHS trust established under this Part of this Act.

National Health Service trusts

NHS trusts.

5.—(1) Subject to subsection (2) or, as the case may be, subsection (3) below the Secretary of State may by order establish bodies, to be known as National Health Service trusts (in this Act referred to as NHS trusts),—

(a) to assume responsibility, in accordance with this Act, for the ownership and management of hospitals or other establishments or facilities which were previously managed or provided by Regional, District or Special Health Authorities; or

(b) to provide and manage hospitals or other establishments or facilities.

(2) In any case where the Secretary of State is considering whether to make an order under subsection (1) above establishing an NHS trust and the hospital, establishment or facility concerned is or is to be situated in England, he shall direct the relevant Regional Health Authority to consult, with respect to the proposal to establish the trust,—

(a) the relevant Community Health Council and such other persons or bodies as may be specified in the direction; and

(b) such other persons or bodies as the Authority considers appropriate;

and, within such period (if any) as the Secretary of State may determine, the relevant Regional Health Authority shall report the results of those consultations to the Secretary of State.

(3) In any case where the Secretary of State is considering whether to make an order under subsection (1) above establishing an NHS trust and the hospital, establishment or facility concerned is or is to be situated in Wales, he shall consult the relevant Community Health Council and such other persons and bodies as he considers appropriate.

(4) In subsections (2) and (3) above—

(a) any reference to the relevant Regional Health Authority is a reference to that Authority in whose region the hospital, establishment or other facility concerned is, or is to be, situated; and

(b) any reference to the relevant Community Health Council is a reference to the Council for the district, or part of the district, in which that hospital, establishment or other facility is, or is to be, situated.

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(5) Every NHS trust—

(a) shall be a body corporate having a board of directors consisting of a chairman appointed by the Secretary of State and, subject to paragraph 5(2) of Schedule 2 to this Act, executive and non-executive directors (that is to say, directors who, subject to subsection (7) below, respectively are and are not employees of the trust); and

(b) shall have the functions conferred on it by an order under subsection (1) above and by Schedule 2 to this Act.

(6) The functions specified in an order under subsection (1) above shall include such functions as the Secretary of State considers appropriate in relation to the provision of services by the trust for one or more health authorities.

(7) The Secretary of State may by regulations make general provision with respect to—

(a) the qualifications for and the tenure of office of the chairman and directors of an NHS trust (including the circumstances in which they shall cease to hold, or may be removed from, office or may be suspended from performing the functions of the office);

(b) the persons by whom the directors and any of the officers are to be appointed and the manner of their appointment;

(c) the maximum and minimum numbers of the directors;

(d) the circumstances in which a person who is not an employee of the trust is nevertheless, on appointment as a director, to be regarded as an executive rather than a non-executive director;

(e) the proceedings of the trust (including the validation of proceedings in the event of a vacancy or defect in appointment); and

(f) the appointment, constitution and exercise of functions by committees and sub-committees of the trust (whether or not consisting of or including any members of the board) and, without prejudice to the generality of the power, any such regulations, may make provision to deal with cases where the post of any officer of an NHS trust is held jointly by two or more persons or where the functions of such an officer are in any other way performed by more than one person.

(8) Part I of Schedule 2 to this Act shall have effect with respect to orders under subsection (1) above; Part II of that Schedule shall have effect, subject to subsection (9) below, with respect to the general duties and the powers and status of NHS trusts; the supplementary provisions of Part III of that Schedule shall have effect; and Part IV of that Schedule shall have effect with respect to the dissolution of NHS trusts.

(9) The specific powers conferred by paragraphs 14 and 15 in Part II of Schedule 2 to this Act may be exercised only to the extent that—

(a) the exercise will not interfere with the duties of the trust to comply with directions under paragraph 6 of that Schedule; and

(b) the exercise will not to any significant extent interfere with the performance by the trust of its obligations under any NHS contract or any obligations imposed by an order under subsection (1) above.

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(10) The Secretary of State may by order made by statutory instrument confer on NHS trusts specific powers additional to those contained in paragraphs 10 to 15 of Schedule 2 to this Act.

Transfer of staff to NHS trusts.

6.—(1) Subject to subsection (5) below, this section applies to any person who, immediately before an NHS trust's operational date—

(a) is employed by a health authority to work solely at, or for the purposes of, a hospital or other establishment or facility which is to become the responsibility of the trust; or

(b) is employed by a health authority to work at, or for the purposes of, such a hospital, establishment or facility and is designated for the purposes of this section by a scheme made by the health authority specified as mentioned in paragraph 3(1)(f) of Schedule 2 to this Act.

(2) A scheme under this section shall not have effect unless approved by the Secretary of State.

(3) Subject to section 7 below, the contract of employment between a person to whom this section applies and the health authority by whom he is employed shall have effect from the operational date as if originally made between him and the NHS trust.

(4) Without prejudice to subsection (3) above—

(a) all the health authority's rights, powers, duties and liabilities under or in connection with a contract to which that subsection applies shall by virtue of this section be transferred to the NHS trust on its operational date; and

(b) anything done before that date by or in relation to the health authority in respect of that contract or the employee shall be deemed from that date to have been done by or in relation to the NHS trust.

(5) In any case where—

(a) an order under section 5(1) above provides for the establishment of an NHS trust with effect from a date earlier than the operational date of the trust, and

(b) on or after that earlier date but before its operational date the NHS trust makes an offer of employment by the trust to a person who at that time is employed by a health authority to work (whether solely or otherwise) at, or for the purposes of, the hospital or other establishment or facility which is to become the responsibility of the trust, and

(c) as a result of the acceptance of the offer, the person to whom it was made becomes an employee of the NHS trust,

subsections (3) and (4) above shall have effect in relation to that person's contract of employment as if he were a person to whom this section applies and any reference in those subsections to the operational date of the trust were a reference to the date on which he takes up employment with the trust.

PART I

(6) Subsections (3) and (4) above are without prejudice to any right of an employee to terminate his contract of employment if a substantial change is made to his detriment in his working conditions; but no such right shall arise by reason only of the change in employer effected by this section.

(7) A scheme under this section may designate a person either individually or as a member of a class or description of employees.

Supplementary provisions as to transfer of staff.

7.—(1) In the case of a person who falls within section 6(1)(b) above, a scheme under that section may provide that, with effect from the NHS trust's operational date, his contract of employment (in this section referred to as "his original contract") shall be treated in accordance with the scheme as divided so as to constitute—

(a) a contract of employment with the NHS trust; and

(b) a contract of employment with the health authority by whom he was employed before that date (in this section referred to as "the transferor authority").

(2) Where a scheme makes provision as mentioned in subsection (1) above,—

(a) the scheme shall secure that the benefits to the employee under the two contracts referred to in that subsection, when taken together, are not less favourable than the benefits under his original contract;

(b) section 6 above shall apply in relation to the contract referred to in subsection (1)(a) above as if it were a contract transferred under that section from the transferor authority to the NHS trust;

(c) so far as necessary to preserve any rights and obligations, the contract referred to in subsection (1)(b) above shall be regarded as a continuation of the employee's original contract; and

(d) for the purposes of section 146 of and Schedule 13 to the Employment Protection (Consolidation) Act 1978, the number of hours normally worked, or, as the case may be, the hours for which the employee is employed in any week under either of those contracts shall be taken to be the total of the hours normally worked or, as the case may be, for which he is employed under the two contracts taken together. 1978 c. 44.

(3) Where, as a result of the provisions of section 6 above, by virtue of his employment during any period after the operational date of the NHS trust,—

(a) an employee has contractual rights against an NHS trust to benefits in the event of his redundancy, and

(b) he also has statutory rights against the trust under Part VI of the Employment Protection (Consolidation) Act 1978 (redundancy payments),

any benefits provided to him by virtue of the contractual rights referred to in paragraph (a) above shall be taken as satisfying his entitlement to benefits under the said Part VI.

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Transfer of property, rights and liabilities to NHS trust.

8.—(1) The Secretary of State may by order transfer or provide for the transfer to an NHS trust, with effect from such date as may be specified in the order, of such of the property, rights and liabilities of a health authority or of the Secretary of State as, in his opinion, need to be transferred to the trust for the purpose of enabling it to carry out its functions.

(2) An order under this section may create or impose such new rights or liabilities in respect of what is transferred or what is retained by a health authority or the Secretary of State as appear to him to be necessary or expedient.

(3) Nothing in this section affects the power of the Secretary of State or any power of a health authority to transfer property, rights or liabilities to an NHS trust otherwise than under subsection (1) above.

(4) Stamp duty shall not be chargeable in respect of any transfer to an NHS trust effected by or by virtue of an order under this section.

(5) Where an order under this section provides for the transfer—

(a) of land held on lease from a third party, that is to say, a person other than the Secretary of State or a health authority, or

(b) of any other asset leased or hired from a third party or in which a third party has an interest,

the transfer shall be binding on the third party notwithstanding that, apart from this subsection, it would have required his consent or concurrence.

(6) Any property, rights and liabilities which are to be transferred to an NHS trust shall be identified by agreement between the trust and a health authority or, in default of agreement, by direction of the Secretary of State.

(7) Where, for the purpose of a transfer pursuant to an order under this section, it becomes necessary to apportion any property, rights or liabilities, the order may contain such provisions as appear to the Secretary of State to be appropriate for the purpose; and where any such property or rights fall within subsection (5) above, the order shall contain such provisions as appear to the Secretary of State to be appropriate to safeguard the interests of third parties, including, where appropriate, provision for the payment of compensation of an amount to be determined in accordance with the order.

(8) In the case of any transfer made by or pursuant to an order under this section, a certificate issued by the Secretary of State that any property specified in the certificate or any such interest in or right over any such property as may be so specified, or any right or liability so specified, is vested in the NHS trust specified in the order shall be conclusive evidence of that fact for all purposes.

(9) Without prejudice to subsection (4) of section 126 of the principal Act, an order under this section may include provision for matters to be settled by arbitration by a person determined in accordance with the order.

Originating capital debt of, and other financial provisions relating to NHS trusts.

9.—(1) Each NHS trust shall have an originating capital debt of an amount specified in an order made by the Secretary of State, being an amount representing, subject to subsection (2) below, the excess of the valuation of the assets which, on or in connection with the establishment

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of the trust, are or are to be transferred to it (whether before, on or after its operational date) over the amounts of the liabilities which are or are to be so transferred.

(2) In determining the originating capital debt of an NHS trust, there shall be left out of account such assets or, as the case may be, liabilities as are, or are of a class, determined for the purposes of this section by the Secretary of State, with the consent of the Treasury.

(3) An NHS trust's originating capital debt shall be deemed to have been issued out of moneys provided by Parliament and shall constitute an asset of the Consolidated Fund.

(4) In accordance with an order under subsection (1) above, an NHS trust's originating capital debt shall be divided between—

(a) a loan on which interest shall be paid at such variable or fixed rates and at such times as the Treasury may determine; and

(b) public dividend capital.

(5) The loan specified in subsection (4)(a) above is in this Part of this Act referred to as an NHS trust's "initial loan" and a rate of interest on the initial loan shall be determined as if section 5 of the National Loans Act 1968 had effect in respect of it and subsections (5) to (5B) of that section shall apply accordingly. 1968. c. 13.

(6) Subject to subsections (4)(a) and (5) above, the terms of the initial loan shall be such as the Secretary of State, with the consent of the Treasury, may determine; and, in the event of the early repayment of the initial loan, the terms may require the payment of a premium or allow a discount.

(7) With the consent of the Treasury, the Secretary of State may determine the terms on which any public dividend capital forming part of an NHS trust's originating capital debt is to be treated as having been issued, and, in particular, may determine the dividend which is to be payable at any time on any public dividend capital.

(8) An order under subsection (1) above shall be made—

(a) with the consent of the Treasury; and

(b) by statutory instrument.

(9) Schedule 3 to this Act shall have effect with respect to—

(a) borrowing by NHS trusts;

(b) the limits on their indebtedness;

(c) the payment of additional public dividend capital to them; and

(d) the application of any surplus funds of NHS trusts.

Financial obligations of NHS trusts.

10.—(1) Every NHS trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) It shall be the duty of every NHS trust to achieve such financial objectives as may from time to time be set by the Secretary of State with the consent of the Treasury and as are applicable to it; and any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

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Trust funds and trustees for NHS trusts.

11.—(1) The Secretary of State may by order made by statutory instrument provide for the appointment of trustees for an NHS trust; and any trustees so appointed shall have power to accept, hold and administer any property on trust for the general or any specific purposes of the NHS trust (including the purposes of any specific hospital or other establishment or facility which is owned and managed by the trust) or for all or any purposes relating to the health service.

(2) An order under subsection (1) above may—

(a) make provision as to the persons by whom trustees are to be appointed and generally as to the method of their appointment;

(b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State);

(c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as he considers appropriate; and

(d) make provision with respect to the term of office of any trustee and his removal from office.

(3) Where, under subsection (1) above, trustees have been appointed for an NHS trust, the Secretary of State may by order made by statutory instrument provide for the transfer of any trust property from the NHS trust to the trustees so appointed.

(4) In section 91 of the principal Act (private trusts for hospitals) in subsection (3) (definition of "the appropriate hospital authority") after paragraph (a) there shall be inserted the following paragraphs—

"(aa) where the hospital is owned and managed by an NHS trust and trustees have been appointed for the NHS trust, those trustees;

(ab) where the hospital is owned and managed by an NHS trust and neither paragraph (a) nor paragraph (aa) above applies, the NHS trust;".

(5) In section 92 of the principal Act (further transfers of trust property)—

(a) in subsection (1) after the word "hospital" there shall be inserted "or other establishment or facility" and for the words "or special trustees", in each place where they occur, there shall be substituted "NHS trust, special trustees or trustees for an NHS trust";

(b) in subsections (2) to (4), after the word "authorities", in each place where it occurs, there shall be inserted "or NHS trusts";

(c) in subsection (2) after the word "authority", there shall be inserted "or NHS trust"; and

(d) at the end of the section there shall be added the following subsection—

"(6) If it appears to the Secretary of State at any time that—

(a) the functions of any special trustees should be discharged by the trustees for an NHS trust, or

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(b) the functions of the trustees for an NHS trust should be discharged by special trustees,

then, whether or not there has been any such change as is mentioned in subsection (1) above, he may, after consulting the special trustees and the trustees for the NHS trust, by order provide for the transfer of all trust property from or to the special trustees to or from the trustees for the NHS trust."

(6) In section 96 of the principal Act (trusts: supplementary provisions)—

(a) any reference to sections 90 to 95 of the principal Act includes a reference to subsections (1) to (3) above; and

(b) after subsection (1) there shall be inserted the following subsection—

"(1A) Where any transfer of property by virtue of those sections is of, or includes,—

(a) land held on lease from a third party, that is to say, a person other than the Secretary of State or a health authority, or

(b) any other asset leased or hired from a third party or in which a third party has an interest,

the transfer shall be binding on the third party notwithstanding that, apart from this subsection, it would have required his consent or concurrence."

(7) In section 98(1) of the principal Act (accounts and audit) after paragraph (d) there shall be inserted—

"(dd) any trustees for an NHS trust appointed in pursuance of section 11 of the National Health Service and Community Care Act 1990; and".

Family Health Services Authorities

Functions of Family Health Services Authorities.

12.—(1) In section 15 of the principal Act (duty of Family Health Services Authority)—

(a) in subsection (1), after the word "regulations" there shall be inserted "and subject to any directions from the relevant Regional Health Authority";

(b) in paragraph (b) of that subsection, after the words "perform such" there shall be inserted "management and"; and

(c) at the end of that subsection there shall be inserted the following subsections—

"(1A) In relation to a Family Health Services Authority for a locality in England, any reference in this Act or the National Health Service and Community Care Act 1990 to the relevant Regional Health Authority is a reference to that Authority in whose region lies the whole or the greater part of the Authority's locality.

(1B) In relation to a medical practitioner, any reference in this Act or the National Health Service and Community Care Act 1990 to the relevant Family Health Services Authority shall be construed as follows,—

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(2) At the end of the paragraph there shall be added the following sub-paragraph— SCH. 1

"(7) In sub-paragraph (1) above "relevant authority" means—

(a) a Regional Health Authority, a District Health Authority or a Family Health Services Authority; or

(b) any special health authority which is specified in Schedule 1 to the Authorities for London Post-Graduate Teaching Hospitals (Establishment and Constitution) Order 1982, in the Board of Governors of the Eastman Dental Hospital (Establishment and Constitution) Order 1984 or in any other provision of an order under this Act which specifies an authority for the purposes of this sub-paragraph." S.I.1982/314. S.I.1984/188

8. In paragraph 10 of that Schedule (staff) at the end of sub-paragraph (1A) there shall be added the words "and a direction under that sub-paragraph may relate to a particular officer or class of officer specified in the direction".

9. In paragraph 12 of that Schedule (regulations as to tenure of office, committees and sub-committees and procedure etc. of authorities)—

(a) at the end of paragraph (a) there shall be added the words "and any members of a committee or sub-committee of an authority who are not members of the authority";

(b) after paragraph (a) there shall be inserted the following paragraph—

"(aa) the circumstances in which a member of an authority who is (or is to be regarded as) an officer of the authority may be suspended from performing his functions as a member"; and

(c) in paragraph (b) after the word "appointment" there shall be inserted "and constitution".

10. After paragraph 12 of that Schedule there shall be inserted the following paragraph—

"12A. Regulations made by virtue of this Schedule or Schedule 1 to the National Health Service and Community Care Act 1990 may make provision (including provision modifying those Schedules) to deal with cases where the post of chief officer or any other officer of an authority is held jointly by two or more persons or where the functions of such an officer are in any other way performed by more than one person."

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Section 5.

NATIONAL HEALTH SERVICE TRUSTS

PART I

ORDERS UNDER SECTION 5(1)

1.—(1) Any reference in this Part of this Schedule to an order is a reference to an order under section 5(1) of this Act establishing an NHS trust or any subsequent order under that provision amending or revoking a previous order.

(2) An order shall be made by statutory instrument.

2. The provisions made by an order shall be in conformity with any general provision made by regulations under section 5(7) of this Act.

3.—(1) Without prejudice to any amendment made by a subsequent order, the first order to be made in relation to any NHS trust shall specify—

(a) the name of the trust;

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(b) the functions of the trust;

(c) the number of executive directors and non-executive directors;

(d) where the trust is to be regarded as having a significant teaching commitment, a provision to secure the inclusion in the non-executive directors referred to in paragraph (c) above of a person appointed from a university with a medical or dental school specified in the order;

(e) the operational date of the trust, that is to say, the date on which the trust is to begin to undertake the whole of the functions conferred on it; and

(f) if a scheme is to be made under section 6 of this Act, the health authority which is to make the scheme.

(2) For the purposes of sub-paragraph (1)(d) above, an NHS trust is to be regarded as having a significant teaching commitment in the following cases—

(a) if the trust is established to assume responsibility for the ownership and management of a hospital or other establishment or facility which, in the opinion of the Secretary of State, has a significant teaching and research commitment; and

(b) in any other case, if the Secretary of State so provides in the order.

(3) In a case where the order contains a provision made by virtue of sub-paragraph (1)(d) above and a person who is being considered for appointment by virtue of that provision—

(a) is employed by the university in question, and

(b) would also, apart from this sub-paragraph, be regarded as employed by the trust,

his employment by the trust shall be disregarded in determining whether, if appointed, he will be a non-executive director of the trust.

(4) An order shall specify the accounting date of the trust.

4.—(1) An order may require a Regional, District or Special Health Authority to make staff, premises and other facilities available to an NHS trust pending the transfer or appointment of staff to or by the trust and the transfer of premises or other facilities to the trust.

(2) An order making provision under this paragraph may make provision with respect to the time when the Regional, District or Special Health Authority's functions under the provision are to come to an end.

5.—(1) An order may provide for the establishment of an NHS trust with effect from a date earlier than the operational date of the trust and, during the period between that earlier date and the operational date, the trust shall have such limited functions for the purpose of enabling it to begin to operate satisfactorily with effect from the operational date as may be specified in the order.

(2) If an order makes the provision referred to in sub-paragraph (1) above, then, at any time during the period referred to in that sub-paragraph, the NHS trust shall be regarded as properly constituted (and may carry out its limited functions accordingly) notwithstanding that, at that time, all or any of the executive directors have not yet been appointed.

(3) If an order makes the provision referred to in sub-paragraph (1) above, the order may require a Regional, District or Special Health Authority to discharge such liabilities of the NHS trust as—

(a) may be incurred during the period referred to in that sub-paragraph; and

(b) are of a description specified in the order.

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PART II

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DUTIES, POWERS AND STATUS

Specific duties

6.—(1) An NHS trust shall carry out effectively, efficiently and economically the functions for the time being conferred on it by an order under section 5(1) of this Act and by the provisions of this Schedule and, with respect to the exercise of the powers conferred by section 5(10) of this Act and paragraphs 10 to 15 below, shall comply with any directions given to it by the Secretary of State, whether of a general or a particular nature.

(2) An NHS trust shall comply with any directions given to it by the Secretary of State with respect to all or any of the following matters—

(a) the qualifications of persons who may be employed as officers of the trust;

(b) the employment, for the purpose of performing functions specified in the direction, of officers having qualifications or experience of a description so specified;

(c) the manner in which officers of the trust are to be appointed;

(d) prohibiting or restricting the disposal of, or of any interest in, any asset which, at the time the direction is given, the Secretary of State reasonably considers to have a value in excess of such sum as may be specified in an order under section 5(1) of this Act and in respect of which the Secretary of State considers that the interests of the National Health Service require that the asset should not be disposed of;

(e) compliance with guidance or directions given (by circular or otherwise) to health authorities, or particular descriptions of health authorities; and

(f) the implementation of awards relating to the distinction or merit of medical practitioners or dental practitioners or any class or classes of such practitioners.

7.—(1) For each accounting year an NHS trust shall prepare and send to the Secretary of State an annual report in such form as may be determined by the Secretary of State.

(2) At such time or times as may be prescribed, an NHS trust shall hold a public meeting at which its audited accounts and annual report and any report on the accounts made pursuant to subsection (3) of section 15 of the Local Government Finance Act 1982 shall be presented. 1982 c. 32.

(3) In such circumstances and at such time or times as may be prescribed, an NHS trust shall hold a public meeting at which such document as may be prescribed shall be presented.

8. An NHS trust shall furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require.

9.—(1) An NHS trust shall be liable to pay—

(a) to the chairman and any non-executive director of the trust remuneration of an amount determined by the Secretary of State, not exceeding such amount as may be approved by the Treasury;

(b) to the chairman and any non-executive director of the trust such travelling and other allowances as may be determined by the Secretary of State with the approval of the Treasury;

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(c) to any member of a committee or sub-committee of the trust who is not also a director such travelling and other allowances as may be so determined.

(2) If an NHS trust so determines in the case of a person who is or has been a chairman of the trust, the trust shall be liable to pay such pension, allowances or gratuities to or in respect of him as may be determined by the Secretary of State with the approval of the Treasury.

(3) Different determinations may be made under sub-paragraph (1) or sub-paragraph (2) above in relation to different cases or descriptions of cases.

Specific powers

10. In addition to carrying out its other functions, an NHS trust may, as the provider, enter into NHS contracts.

11. An NHS trust may undertake and commission research and make available staff and provide facilities for research by other persons.

12. An NHS trust may—

(a) provide training for persons employed or likely to be employed by the trust or otherwise in the provision of services under the principal Act; and

(b) make facilities and staff available in connection with training by a university or any other body providing training in connection with the health service.

13. An NHS trust may enter into arrangements for the carrying out, on such terms as seem to the trust to be appropriate, of any of its functions jointly with any Regional, District or Special Health Authority, with another NHS trust or with any other body or individual.

14. According to the nature of its functions, an NHS trust may make accommodation or services or both available for patients who give undertakings (or for whom undertakings are given) to pay, in respect of the accommodation or services (or both) such charges as the trust may determine.

15. For the purpose of making additional income available in order better to perform its functions, an NHS trust shall have the powers specified in section 7(2) of the Health and Medicines Act 1988 (extension of powers of Secretary of State for financing the Health Service).

1988 c. 49.

General powers

16.—(1) Subject to Schedule 3 to this Act, an NHS trust shall have power to do anything which appears to it to be necessary or expedient for the purpose of or in connection with the discharge of its functions, including in particular power—

(a) to acquire and dispose of land and other property;

(b) to enter into such contracts as seem to the trust to be appropriate;

(c) to accept gifts of money, land or other property, including money, land or other property to be held on trust, either for the general or any specific purposes of the NHS trust or for all or any purposes relating to the health service; and

(d) to employ staff on such terms as the trust thinks fit.

(2) The reference in sub-paragraph (1)(c) above to specific purposes of the NHS trust includes a reference to the purposes of a specific hospital or other establishment or facility which is owned and managed by the trust.

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17.—(1) Without prejudice to the generality of paragraph 16 above, for or in respect of such of its employees as it may determine, an NHS trust may make such arrangements for providing pensions, allowances or gratuities as it may determine; and such arrangements may include the establishment and administration, by the trust or otherwise, of one or more pension schemes.

(2) The reference in sub-paragraph (1) above to pensions, allowances or gratuities to or in respect of employees of an NHS trust includes a reference to pensions, allowances or gratuities by way of compensation to or in respect of any of the trust's employees who suffer loss of office or employment or loss or diminution of emoluments.

Status

18. An NHS trust shall not be regarded as the servant or agent of the Crown or, except as provided by this Act, as enjoying any status, immunity or privilege of the Crown; and an NHS trust's property shall not be regarded as property of, or property held on behalf of, the Crown.

PART III

SUPPLEMENTARY PROVISIONS

Re-imbursement for health services work carried out otherwise than under NHS contract

19.—(1) In any case where an NHS trust provides goods or services for the benefit of an individual and—

(a) the provision of those goods or services is not pursuant to an NHS contract, and

(b) the condition of the individual is such that he needs those goods or services and, having regard to his condition, it is not practicable before providing them to enter into an NHS contract for their provision, and

(c) the provision of those goods or services is within the primary functions of a District Health Authority or is a function of a health board,

the trust shall be remunerated by that Authority or health board in respect of the provision of the goods or services in question.

(2) The rate of any remuneration payable by virtue of sub-paragraph (1) above shall be calculated in such manner or on such basis as may be determined by the Secretary of State.

20. In any case where an NHS trust provides goods or services for the benefit of an individual and—

(a) the provision of those goods or services is not pursuant to an NHS contract, and

(b) the individual is resident outside the United Kingdom and is of a description (being a description associating the individual with another country) specified for the purposes of this paragraph by a direction made by the Secretary of State,

the trust shall be remunerated by the Secretary of State in respect of the provision of the goods or services in question at such rate or rates as he considers appropriate.

Supply of goods and services by local authorities

21. In section 28 of the principal Act (supply of goods and services by local authorities) in subsection (3) after the words "health authorities", in each place where they occur, there shall be inserted "and NHS trusts", and at the end there shall be added "and the National Health Service and Community Care Act 1990".

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Making of charges

22. In each of sections 81 (charges for more expensive supplies) and 82 (charges for repairs and replacement necessitated by an act or omission of the person supplied etc.) of the principal Act, in paragraph (a)—

(a) after the words "Secretary of State" there shall be inserted "or an NHS trust"; and

(b) after the word "him" there shall be inserted "or, as the case may be, by the trust".

Power to raise money by appeals etc.

23.—(1) In section 96A of the principal Act (power of health authorities etc. to raise money etc. by appeals, collections etc.) in subsection (1), after the word "authority", in each place where it occurs, there shall be inserted "or NHS trust".

(2) In subsections (3), (4) and (7) to (9) of that section, for the words "authority or Board", in each place where they occur, there shall be substituted "authority, NHS trust or Board".

(3) In subsection (5), of that section, for the words from "Area or District" onwards there shall be substituted "body responsible for the hospital if that body and the special trustees agree; and in this subsection the body responsible for a hospital is,—

(a) in the case of a hospital vested in a NHS trust, that trust; and

(b) in any other case, the District Health Authority exercising functions on behalf of the Secretary of State in respect of the hospital".

(4) After subsection (5) of that section there shall be inserted the following subsection—

"(5A) Where property is given in pursuance of this section on trust for any purposes of an NHS trust for which trustees have been appointed under section 11(1) of the National Health Service and Community Care Act 1990, then, if those trustees and the NHS trust agree, the property may be held, administered and applied by those trustees instead of by the NHS trust."

(5) In subsection (6) of that section for the words "or to special trustees" there shall be substituted "to an NHS trust or to special trustees or trustees for an NHS trust".

Accounts and audit

24.—(1) In section 98 of the principal Act (accounts and audit), in subsection (1) after paragraph (bb) there shall be inserted—

"(bbb) every NHS trust".

(2) After subsection (2A) of that section there shall be inserted—

"(2B) in preparing its annual accounts in pursuance of subsection (2) above, an NHS trust shall comply with any directions given by the Secretary of State with the approval of the Treasury as to—

(a) the methods and principles according to which the accounts are to be prepared; and

(b) the information to be given in the accounts."

Protection of members and officers

25. In section 125 of the principal Act (protection of members and officers of health authorities etc.)—

(a) for paragraph (b) there shall be substituted—

"(b) an NHS trust"; and

(b) at the end there shall be added "and the National Health Service and Community Care Act 1990".

Compulsory acquisition

26.—(1) An NHS trust may be authorised to purchase land compulsorily for the purposes of its functions by means of an order made by the trust and confirmed by the Secretary of State.

(2) Subject to sub-paragraph (3) below, the Acquisition of Land Act 1981 shall apply to the compulsory purchase of land under this paragraph. 1981 c. 67.

(3) No order shall be made by an NHS trust under Part II of the Acquisition of Land Act 1981 with respect to any land unless the proposal to acquire the land compulsorily—

(a) has been submitted to the Secretary of State in such form and together with such information as he may require: and

(b) has been approved by him.

Use and development of consecrated land and burial grounds

27. Section 128 of the Town and Country Planning Act 1971 (use and development of consecrated land and burial grounds) applies to consecrated land and land comprised in a burial ground, within the meaning of that section, which an NHS trust holds for any of its purposes as if— 1971 c. 78.

(a) that land had been acquired by the trust as mentioned in subsection (1) of that section: and

(b) the trust were a statutory undertaker, within the meaning of that Act.

Instruments etc.

28.—(1) The fixing of the seal of an NHS trust shall be authenticated by the signature of the chairman or of some other person authorised either generally or specially by the trust for that purpose and of one other director.

(2) Any document purporting to be a document duly executed under the seal of an NHS trust shall be received in evidence and shall, unless the contrary is proved, be deemed to be so executed.

(3) A document purporting to be signed on behalf of an NHS trust shall be received in evidence and shall, unless the contrary is proved, be deemed to be so signed.

PART IV

DISSOLUTION

29.—(1) The Secretary of State may by order made by statutory instrument dissolve an NHS trust.

(2) An order under this paragraph may be made—

(a) on the application of the NHS trust concerned; or

(b) if the Secretary of State considers it appropriate in the interests of the health service.

(3) Except where it appears to the Secretary of State necessary to make an order under this paragraph as a matter of urgency, no such order shall be made until after the completion of such consultation as may be prescribed.

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30.—(1) If an NHS trust is dissolved under this Part of this Schedule, the Secretary of State may by order transfer or provide for the transfer to—

(a) the Secretary of State, or

(b) a health authority, or

(c) another NHS trust,

of such of the property, rights and liabilities of the NHS trust which is dissolved as in his opinion is appropriate; and any such order may include provisions corresponding to those of section 8 of this Act.

(2) An order under this paragraph may make provision in connection with the transfer of staff employed by or for the purposes of the NHS trust which is dissolved; and such an order may include provisions corresponding to those of sections 6 and 7 of this Act, including provision for the making of a scheme by such health authority or other body as may be specified in the order.

(3) No order shall be made under this paragraph until after completion of such consultation as may be prescribed.

31. Without prejudice to the generality of paragraph 30 above, if an NHS trust is dissolved under this Part of this Schedule, the Secretary of State or such other NHS trust or health authority as he may direct shall undertake the responsibility for the continued payment of any such pension, allowances or gratuities as, by virtue of paragraph 9(2) or paragraph 17 above, would otherwise have been the responsibility of the trust which has been dissolved.

32. An NHS trust may not be dissolved or wound up except in accordance with this Part of this Schedule.

Section 9.

SCHEDULE 3

FINANCIAL PROVISIONS RELATING TO NHS TRUSTS

Borrowing

1.—(1) Subject to the provisions of this paragraph and to any limit imposed under the following provisions of this Schedule, for the purpose of its functions an NHS trust may borrow (both temporarily, by way of overdraft, and longer term) from the Secretary of State or from any other person.

(2) An NHS trust may not mortgage or charge any of its assets or in any other way use any of its assets as security for a loan.

(3) Except with the consent of the Secretary of State, an NHS trust may not borrow in any currency other than sterling; and the Secretary of State shall not give his consent to any such borrowing except with the approval of the Treasury.

(4) Interest on any sums borrowed from the Secretary of State by an NHS trust shall be paid at such variable or fixed rates and at such times as the Treasury may determine.

1968 c. 13.

(5) A rate of interest under sub-paragraph (4) above shall be determined as if section 5 of the National Loans Act 1968 had effect in respect of it and subsections (5) to (5B) of that section shall apply accordingly.

(6) Subject to sub-paragraphs (4) and (5) above, the terms on which any sums are borrowed from the Secretary of State by an NHS trust shall be such as he may determine; and, in the event of the early repayment of any sums so borrowed, such terms may require the payment of a premium or allow a discount.

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Guarantees of borrowing

2.—(1) The Secretary of State may guarantee, in such manner and on such conditions as, with the approval of the Treasury, he considers appropriate, the repayments of the principal of and the payment of interest on any sums which an NHS trust borrows from a person other than the Secretary of State.

(2) Immediately after a guarantee is given under this paragraph, the Secretary of State shall lay a statement of the guarantee before each House of Parliament.

(3) Where any sum is issued for fulfilling a guarantee so given, the Secretary of State shall lay before each House of Parliament a statement relating to that sum as soon as possible after the end of each financial year beginning with that in which the sum is issued and ending with that in which all liability in respect of the principal of the sum and in respect of interest on it is finally discharged.

(4) If any sums are issued in fulfilment of a guarantee given under this paragraph, the NHS trust concerned shall make to the Secretary of State, at such times and in such manner as the Secretary of State may from time to time direct,—

(a) payments of such amounts as the Secretary of State with the consent of the Treasury so directs in or towards repayment of the sums so issued; and

(b) payments of interest, at such rates as the Secretary of State with the consent of the Treasury so directs, on what is outstanding for the time being in respect of sums so issued.

Limits on indebtedness

3.—(1) The aggregate of all sums borrowed by NHS trusts established to assume responsibility for the ownership and management of, or to provide and manage, hospitals or other establishments or facilities which are situated in England shall not exceed £5,000 million or such other sum not exceeding £10,000 million as may be specified by order made by the Secretary of State with the consent of the Treasury.

(2) The aggregate of all sums borrowed by NHS trusts established to assume responsibility for the ownership and management of, or to provide and manage, hospitals or other establishments or facilities which are situated in Wales shall not exceed £300 million or such other sum not exceeding £600 million as may be specified by order made by the Secretary of State with the consent of the Treasury.

(3) The references in sub-paragraphs (1) and (2) above to sums borrowed do not include a reference to NHS trusts' initial loans.

4. Any power to make an order under paragraph 3 above shall be exercisable by statutory instrument which shall be subject to annulment in pursuance of a resolution of the House of Commons.

Additional public dividend capital

5.—(1) If the Secretary of State, with the consent of the Treasury, considers it appropriate to do so, he may, instead of making a loan to an NHS trust under paragraph 1 above, pay an amount to the trust as public dividend capital.

(2) Section 9 of this Act shall apply to public dividend capital paid to an NHS trust under this paragraph as it applies to public dividend capital forming part of the trust's originating capital debt.

Surplus funds

ars to the Secretary of State that any amount standing in the
HS trust is surplus to its foreseeable requirements, the trust shall,
of State with the approval of the Treasury and after consultation
o directs, pay that amount into the Consolidated Fund.

Investment

rust may not invest any money held by it except in securities of the
f the United Kingdom or in such other manner as the Secretary of
the consent of the Treasury approve.

SCHEDULE 4

TS OF PART III OF THE LOCAL GOVERNMENT FINANCE ACT 1982

ection 11 (establishment of Audit Commission), in subsection (1)
ls "Local Authorities" there shall be inserted "and the National
".

ction (2) of that section,—

e word "thirteen" there shall be substituted "fifteen";

e word "seventeen" there shall be substituted "twenty"; and

aragraphs (a) and (b) there shall be substituted the words "such
nisations and other bodies as appear to him to be appropriate".

section 12 (accounts subject to audit), in subsection (2) after
there shall be inserted—

a) a body specified in section 98(1) of the National Health Service
Act 1977".

ubsection (3) of that section there shall be inserted the following

) This section also applies to the accounts of the members of a
sed fund-holding practice so far as they relate to allotted sums paid
, and subject to subsection (3B) and section 16(1A) below, any
e in this Part of this Act to the accounts of a body shall be
ed, in relation to the members of a fund-holding practice, as a
e to such of their accounts as relate to allotted sums so paid.

In such circumstances and to such extent as regulations made by
retary of State so provide, this Part of this Act shall not apply to the
ts for any year of the members of a recognised fund-holding practice
accounts are submitted to a Family Health Services Authority and
rised in that Authority's accounts.

In subsection (3A) above "allotted sums" has the same meaning

SWEDEN

Nera Report

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Financing Health Care with
Particular Reference to Medicines

Volume 11

THE HEALTH CARE SYSTEM IN SWEDEN

n/e/r/a

National Economic Research Associates

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CHAPTER 1
PROFILE OF THE HEALTH CARE SYSTEM

1.1 SUMMARY

- Structure

Sweden has a national, yet decentralised, health care system. The provision of most health care services is the responsibility of 26 public authorities which are based on regional or local territories. These regional authorities also pay for most benefits in kind. A national insurance system, also with 26 regional offices, pays health care benefits in cash and reimburses a relatively small amount of work carried out by private physicians.

The regional authorities are independent organisations run by elected politicians. Each authority provides health care for its own resident population.

The national government of Sweden is responsible for making health care laws, but not for implementing them. Nevertheless, it retains some influence over the health care system. Many policy decisions, including wage negotiations with physicians and clinicians, are made centrally through the national organisation of the regional authorities.

- Aggregate Level of Expenditure

The regional authorities determine the aggregate level of expenditure on health care. Each regional authority can levy taxes to generate income, and the main use of the tax revenue is to finance health care. However, in the last two years the national parliament of Sweden has passed legislation which effectively prohibits regional authorities from increasing tax rates.

The national insurance system is financed through payroll tax contributions. Their level is determined annually by the national parliament.

- Incentives

Primary Care Physicians: public primary care physicians are not in competition with each other, since they are reimbursed on a salaried basis. They therefore have little financial incentive either to provide high quality service or to expand the volume of their work. Private primary care physicians, however, are paid on a fee-for-service basis, and therefore do have a financial incentive to expand volume.

Hospitals: in general hospitals have an incentive to provide health care cost-effectively. This is so because they receive a global budget, and because hospital managers are accountable to (elected) members of the regional authority boards.

Funders: since (and indeed even before) regional authorities were prohibited from increasing the tax contributions of their resident population, they have introduced a multitude of regionally based reform models. These are predominantly aimed at a more efficient provision of health care.

- Issues

The main issues are:

- There are significant differences in the levels of productivity and quality of care across hospitals.
- Primary and secondary care are not well integrated.
- The absence of a family doctor system leads to a large number of self-referrals to hospitals by Swedes.
- Local and regional authorities have an incentive to shift the responsibility (and hence the financial burden) for some types of care onto each other.

- Medicines

To comply with regulations by the European Community, the Swedish government has introduced legislation which will separate price controls on medicines from their registration procedure. From 1 January 1993 a reference price system will apply. In the first instance this will cover multi-source substances, i.e. generic equivalents.

- Reforms

Reforms aimed at stimulating competition between providers, by setting up an internal market, are currently being introduced in a number of regions. More far reaching reforms have been proposed by the national organisation of the regional authorities, and are being considered by a parliamentary committee.

- Political Environment

Sweden's present interest in health care reform has to be seen against a wider background. The country is currently re-examining its role as an advanced welfare state and is contemplating adapting its social and economic framework to bring it more into line with that of other European countries.

1.2 THE STRUCTURE OF THE HEALTH CARE SYSTEM

1.2.1 The Health Care System in Context

Sweden has a population of approximately 8.6 million people, spread over 450,000 square km. Its population density is one of the lowest in Europe. About 90 percent of Swedes live in the Southern half of country, and about 20 percent live in the three largest cities Stockholm, Malmö, and Göteborg.

Local self-government has a long tradition in Sweden. There are two kinds of local government units in Sweden: on the regional level, these are the county councils (*Landsting*), and on the local level they are the municipalities (*Kommun*). There are 23 county councils, whose territories normally coincide with the national government's regional administrative unit, the county (*Län*). An exception concerns the three large municipalities which are not part of a county council, namely the cities of Göteborg and Malmö, and the island of Gotland.

Parliamentary elections on all three levels, i.e. national, regional (county council) and local (municipality) level, take place every three years on the same day. The national parliament (*Riksdag*) elects the Prime Minister.

The legal framework of the Swedish health care system is laid down in the Health Care and Medical Services Act (*Hälso-och Sjukvardslagen*) of 1982, and amended in 1985. The Ministry of Health and Social Affairs (*Socialdepartementet*) is responsible for making health care laws. Their implementation, however, is largely the responsibility of county councils.

The Act defines the terms health and medical care, and makes provisions for county council responsibilities, as well as supervisory activities of the national government.[1] According to the Act, the fundamental goals of health care are "good health and health care on equal conditions for the entire population".[2] County councils are required, under the Act, to promote the health of their residents, to offer equal access to good medical care, and to plan the development and organization of health care.[3]

The Local Government Act stipulates that county councils and municipalities 'conduct their own affairs'. This independence finds an expression in the fact that all three tiers of government have the right to levy taxes. Constitutionally, each level of government

---

1 In addition, there is the Supervision of Health Care and Medical Personnel Act, which contains general provisions concerning the duties of health and medical personnel; and the Health Care and Medical Services Advisory Board Act, which requires county councils to set up advisory boards to promote contacts between patients and staff.

2 Health Care and Medical Services Act, Section 2.

3 Health Care and Medical Services Act, Section 3.

is free to set taxes as it wishes, but in practice, tax rates are coordinated amongst the different tiers with the national government increasingly setting limits to overall taxation. The government is generally able to enforce its views, if necessary by threatening to withhold subsidies to councils.

1.2.2 General Features of the Finance and Delivery System

Sweden has a national, yet decentralised, health service. It is predominantly organised on the regional level with some involvement from the local level and with intervention from the national level. Funding and provision of health care services, other than long-term care for the elderly, are the responsibilities of the county councils. Long-term care for the elderly has recently been transferred to the local municipalities.

Health care is therefore predominantly the responsibility of county councils. Approximately 80 percent of their expenditure is allocated to health care. This expenditure is financed partly through regional income taxes which county councils levy directly on their population. County councils are also supported by state grants, and receive a capitated budget from the national social insurance fund.

A break-down of budgets of county councils, averaged over county councils, is as follows:

Health Care	78 %
Social Welfare	1 %
Care for the Mentally Retarded	8 %
Educational and Cultural Activities	5 %
Administration	8 %
TOTAL	**100 %**

Source: Federation of Swedish County Councils (1989), p. 8.

Benefits in cash for health care are paid by the national insurance system. This was established in Sweden in 1955. Membership of the national insurance scheme is compulsory for all Swedes above the age of sixteen. The insurance system covers four types of social insurance: health care, work-related accidents, pension care and unemployment. On health care matters, the national social insurance system is responsible for the payments of benefits in cash to the insured population. The national insurance system is administered by the National Social Insurance Board (*Riksförsäkringsverket*) through its 26 regional offices.

On the delivery side, there is a public primary care sector, a private primary care sector and a hospital sector. Public primary physicians are salaried employees of the county

councils. A small number of full-time private primary physicians exist. They are reimbursed on a fee-for-service basis by the national insurance system. Public physicians may be allowed by their employer, the county councils, to do part-time private work in addition to their public sector work. For this they receive fee-for-service payments in addition to their salary. Fee-for-service payments are made through the national insurance system. Hospital clinicians are salaried employees of the county councils.

Primary and hospital care are not closely integrated. There is no family doctor system in Sweden. Patients can either go to a primary physician or refer themselves directly to the hospital. Primary physicians often work as groups in health care centres. This means that the individual patient has no guarantee of seeing the same doctor at each visit.

1.2.3 Inputs and Outputs of the System

Health care expenditure in Sweden in 1988 was SEK 88,637 million ($10.6 bn 1990),[4] or 9.4 percent of gross domestic product (GDP).[5] Chart 1.1 shows how this figure is allocated to payers and sectors.

Health care expenditure in 1988 was comprised as follows: 59 percent was funded out of county council taxation, and 7 percent was funded from municipality taxation. Contributions from the National Social Insurance Board and the national government amounted to 23 percent, while the remaining 11 percent of funding came from patient copayments.

By international comparisons, Sweden has achieved a high standard of health. In 1990, infant mortality was 5.7 deaths in the first year per 1,000 births, which is low[6] compared to the average figure of 7.6 for the countries included in this study.[7] Average life expectancy at birth in 1989 was 75 years for males and 81 years for females,[8] compared to the average of 73 for males and 80 for females for the countries included in the study. Life expectancy in Sweden has increased by two years in the

---

4 Throughout this Report, values are given in local currency and in 1990 US$. Conversions are made at 1990 Purchasing Power Parities. Further, figures in 1990 US$ are effectively equivalent to 1990 ECUs, for while the current $/ECU exchange rate is 1 ECU = $1.382 (Financial Times, 6 August 1992), 1990 Purchasing Power Parity suggests a rate of 1 ECU = $1.021. Source: OECD, 1992 (1992a); OECD (1992b).

5 If the care for mentally disabled people is excluded (as the United Nations has recommended), health care spending as a percentage of GDP stands at 8.5. For 1990, health care spending as a percentage of GDP is 9.3 (including care for mentally disabled people), or 8.6 (excluding mentally disabled people).

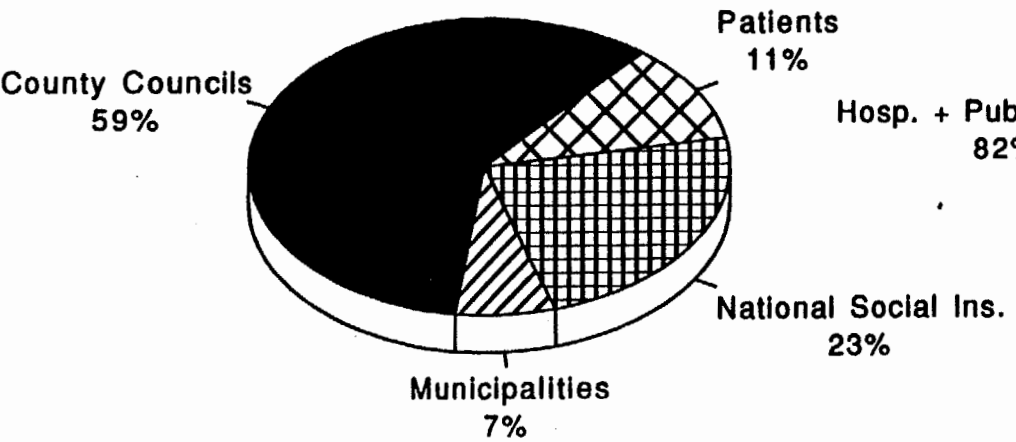
6 OECD (1991).

7 The countries are Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Spain, Sweden, the UK and the USA.

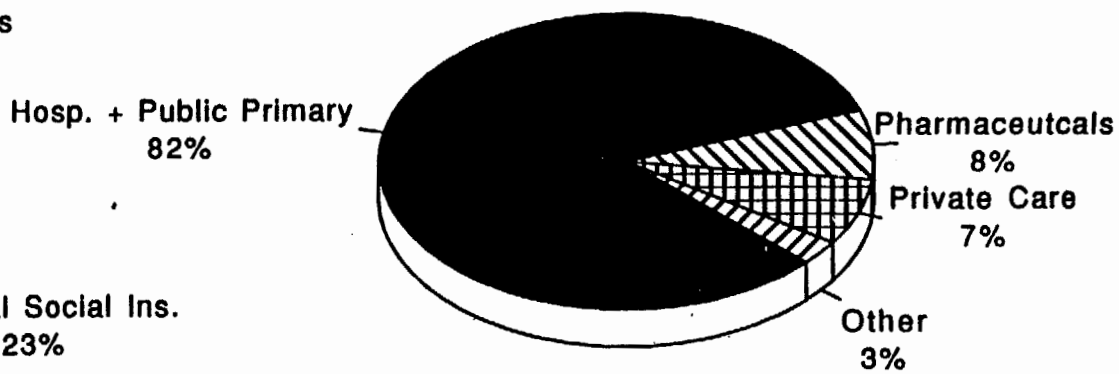
8 OECD (1991).

Chart 1.1
Expenditure on Health Care in Sweden, 1988

By Source
Total Spending: SEK 88,637 million



By Sector
Total Spending: SEK 88,637 million



urce: Haelsan I Sverige 1991/92, p.196

last decade for both sexes. However, if indicators such as sick leave and early retirement are taken as measures of morbidity, then the recent rise in these indicators can be cited as evidence for a possible increasing morbidity rate in Sweden.[9]

The need for health care in Sweden as measured by the proportion of elderly in the population, is rising. In 1990, approximately 18 percent of the population was 65 years or older, and 8 percent was 75 years or older.[10] Sweden thus has the largest percentage of elderly people of all our country studies.[11] The share of the 75 years or older age group may increase to more than 10 percent by the year 2025.

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9 The high incidence of sick leave and early retirement has also been interpreted as the being the result of generous payment rules for individuals.

10 OECD (1991).

11 The (unweighed) average share of the population aged 65 years or older in our country studies is 13.6. That of the population aged 75 years or older is 5.9.

1.3 ANALYSIS OF INDIVIDUAL SECTORS

1.3.1 Key Participants in the Health Care System

Chart 1.2 presents an overview of the financial and delivery flows in the Swedish health care system. It also introduces the main participants in this system. These are:

- The patients, who are also taxpayers and members of the national insurance scheme;
- the National Government, especially the Ministry of Health and Social Affairs and the National Board of Health and Welfare;
- the local and regional authorities, i.e. the municipalities and county councils, and the Federation of County Councils;
- the National Social Insurance Board and its regional offices;
- primary physicians, either private or salaried;
- hospitals and long-term care institutions;
- hospital clinicians; and,
- the pharmaceutical sector.

In this Section we will describe the role of each of these key participants.

1.3.2 Patients

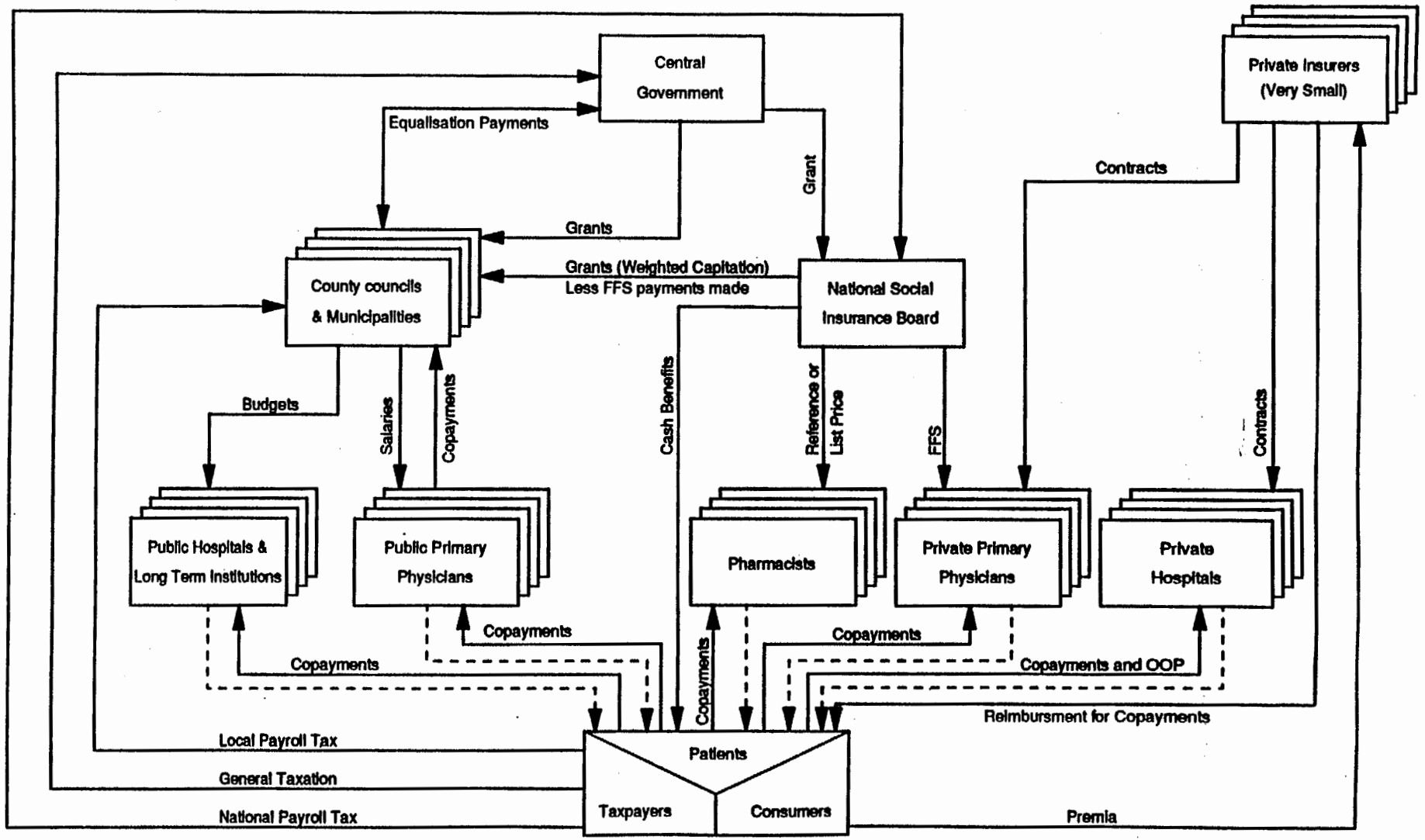
1.3.2.1 Attitudes towards the Health Care System

A survey conducted in 1990 to find out about people's perception of their health service revealed some surprising results.[12] The study was carried out in ten countries and thus allows for comparisons across these on the level of satisfaction with health care services in these countries. Of 500 Swedes questioned, 58 percent thought that the Swedish health care system needed fundamental changes. This was significantly higher than in any other country bar the United States, where the figure was 60 percent.

On the other hand, when asked whether the Swedish health care system should be completely rebuilt, only 6 percent replied that it should - significantly less than in most countries included in the survey. Only for Japan, Canada and the Netherlands was the comparable figure the same or marginally lower. Although the data needs to interpreted with great care, the findings suggest that many Swedes are dissatisfied with aspects of their health care system. At the same time they appear to have preference for health care reforms which do not fundamentally alter its governing principles. Swedes tend to agree with the basic structure of the health care system, but nevertheless favour changes.

[12] See Blendon, R; Leitman, R; Morrison, I; Donelan, K (1990), pp. 185 -192.

Chart 1.2
Key Participants in the Health Care System in Sweden



1.3.2.2 Roles and Objectives of the Patient

As noted earlier, patients may refer themselves directly to hospitals in Sweden, rather than being referred there by their physicians. In fact, about 40 percent of the yearly visits to doctors in Sweden take place in outpatient departments of hospitals. This is partly because, in the absence of family doctors, the difference between going to a primary physicians' (group) practice or an outpatient department of a hospital is insignificant for many Swedes.

A crude indication where Swedes go to for what ailments, if they have a choice of a primary care centre and a hospital, is given by the following table:

Primary Care Centre		Hospital
47%	Colds	6%
3%	Stomach Symptoms	14%
9%	Accidents	48%
2%	Chest Pains	7%
20%	Sickness Certificate	11%
19%	Other	14%
100%	**TOTAL**	**100%**

Source: SPRI 1987, p.5.

In the Swedish health care system, the patient is relatively uninvolved in the decision making process. Socially this appears to manifest itself in a widespread feeling that patients have little choice. Because of the absence of a family doctor system, the patient does not have an agent who acts as a source of information and guidance on health care.

Copayments exist for most services which a patient wishes to make use of, e.g. for visits to primary physicians, to hospitals and for medicines. There is a total copayment limit per annum for any patient which covers physician visits, outpatient treatment and drugs, but not inpatient stays. In 1992, the limit on average was SEK 1,500 ($137 1990). In 1993 this will be increased to SEK 1,600. County councils can, however, set lower limits.

Complaints from patients on possible malpractice can be directed either to the National Board of Health and Welfare, or to the National Medical Disciplinary Board. The latter may withdraw the accreditation of a physician or a nurse, or limit the right of the person to practice in the health profession. The National Medical Disciplinary Board

receives approximately 1,500 complaints a year from patients or their relatives. Patients are eligible for a (usually small) financial compensation for maltreatment.

1.3.3 Payers

1.3.3.1 Roles and Objectives

As a basic rule, the responsibility for the funding of services in each county is as follows: county councils pay for most benefits in kind, while insurance funds pay for benefits in cash.

The responsibility to provide and purchase health care services in Sweden is mainly allocated to county councils. County councils were set up in 1862. The population of a county council ranges from 60,000 to 1,700,000, the average being 300,000. More than 400,000 people are employed by the county councils, or almost 10 percent of the workforce. Their responsibility comprises medical services, mental health care, care for the disabled, dental care, preventative care and public health. Some county councils also pay a part of the medical and dental training, but the bulk is usually financed by the national government.

Municipalities have no responsibility for health care other than long-term care for the elderly. Their main responsibilities are the provision of schools, electricity supply, water supply, sewerage and waste management, as well as housing and social and welfare services. There are 284 municipalities with populations ranging from 5,000 to 700,000 and averaging 30,000.

The Federation of County Councils (*Landstingsförbundet*) is a national organisation of the county councils. Although it has no legal status, it has developed into a considerably powerful organisation over the years. Approximately 180 people work in the Federation which has only one central office, in Stockholm.

Representatives of the political parties in the county councils choose delegates to the congress, which is the highest decision-making body of the Federation of County Councils. The congress then elects the Federation's executive committee and the auditors. The executive committee is assisted by various special committees, such as the finance committee or the collective bargaining and personnel committee. Congress meets yearly, and elections take place every three years.

The Federation of County Councils is also an employer organization which centrally negotiates the salaries for primary physicians, nurses and clinicians with representatives of their trade unions. It is thus a monopsony buyer of health care personnel. The outcome of the wage negotiations are binding for all individual county councils. Doctors and nurses are represented in these negotiations by their trade unions, which are basically the Swedish Medical Association, and the Swedish Association of Nurses and Midwives. There are no significant differences in the salary structure of hospital

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clinicians and ambulatory physicians, but there are differences between doctors working in rural and in urban areas. Both groups are paid primarily a salary which is based on hours worked. Overtime and working unsocial hours, e.g. at nights and on weekends, command additional pay.

The Federation of County Councils negotiates with the government the total amount of grants which county councils receive. Furthermore, it has an advisory function to the Ministry of Finance.

Within each county council there exist primary and secondary health care districts. In some cases, one or more primary health care district will be completely contained within the boundaries of a secondary health care district. In other cases these boundaries are not co-terminous. Municipalities are smaller units than county councils but their boundaries are not necessarily co-terminous with either primary health care districts or secondary health care districts.[13]

Most health care districts are headed by a Director whose duty is the planning of primary and hospital services in a district. The Director is responsible to a Board of politically appointed officials.

The National Social Insurance Board employs 14,000 people in its 26 regional offices. The boundaries of these 26 offices correspond to the boundaries of the 23 county councils and the three municipalities which are not part of a county council (i.e. Göteborg, Malmö and the island of Gotland). The National Social Insurance Board is located in Stockholm and employs 500 people. It is run by a board whose members are appointed by the government.

The benefits in cash to which Swedes are entitled under the national insurance scheme include:

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[13] Below are two examples of how services are organised within county councils:

(1) *Malmöhus Landsting* has six health care districts. Each district has primary care facilities. Five out of six districts each have one hospital. The board and the managing directors at district levels are responsible for the provision of both primary care and hospital care. The heads of the clinical departments report directly to the managing director of the district.

(2) *Älvsborgs Landsting* has ten primary care districts and two districts ('North' and 'South') that comprise acute and psychiatric hospitals. In the 'northern' hospital district there is one large hospital. In the 'southern' district there are three smaller hospitals. Each hospital district, and each primary care district, is headed by a board and a managing director. The heads of the clinical departments report directly to the managing director of the hospital district.

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Benefits in Cash

- **Sickness Benefits:**
  From March 1991, this amounts to 60 percent of normal income for the first three days of illness, 80 percent from the fourth to the 90th day of illness, 90 percent thereafter. The daily minimum benefit is SEK 60 ($5.51 1990). No sickness benefit is payable on that portion of gross annual income which exceeds SEK 241,500 ($22,200 1990). Sickness benefits are taxable. To qualify for sickness benefit, the person concerned must have reported sick to the social insurance office. The regulations have recently been changed, and the employer now makes the payments for the first fourteen days, after which the health insurance system takes over.

- **Parental Benefits:**
  The parental insurance scheme provides parental benefits for 450 days, starting two months before the expected date of child birth and lasting until the child is eight years old. Parents themselves decide how to allocate the 450 days of leave between them, but it is not possible for both to receive the benefits at the same time, except for ten days after the child is born. The benefit amounts to 90 percent of gross income for 360 days, with a daily minimum of SEK 60 ($5.51 1990), and a flat rate of SEK 60 ($5.51 1990) per day for another 90 days. Parental benefits are taxable. Parents are also entitled to the benefit if they adopt children under 10 years of age. There are further regulations in case of illness of a child.

- **Maternity Benefits:**
  If an expected mother is not able to work in her normal capacity due to her condition, she receives a maternity benefit which is equivalent to the parental benefits for a maximum of 50 days before the expected date of childbirth.

- **Other Benefits:**
  Other benefits in cash include allowances for medical expenses, travel expenses to and from hospitals, and rebates on medicines.

A private health care insurance sector exists, but it is very small. It basically provides insurance cover against copayments, and, significantly, insurance cover for better access to physicians and hospitals for treatments, in cases where waiting lists are in operation. In these cases, the privately insured patient does not jump the queue in order to receive treatment in a public hospital. Rather, better access means that patients are referred to private physicians and private acute hospitals. Thus private insurers hold contracts with private physicians and private hospitals.

1.3.3.2 Degree of Choice for the Insured

Purchasing and provision of health care services is largely the responsibility of the council of the patient's county of residence. Hence, patients have no choice of insurer, unless they move to a different county. Similarly, as insurance fund members, Swedes have no choice but to belong to the regional insurance board of their county of residence. The latter, however, is unlikely to matter, as contributions and benefits are the same throughout the country.

1.3.3.3 Funding of the Payers

Health care expenditure of county councils (and municipalities) are financed through taxation raised predominantly at the local level. Specific tasks, such as research and education of medical doctors, are either funded centrally by the national government, or by the county councils.

In 1990, the average county council tax rate, a proportional payroll tax with no upper contribution limit, was 14.0 percent. It ranged from 12.75 percent to 14.5 percent (for Stockholm). The average municipality tax rate, also a proportional payroll tax with no upper contribution limit, was 17.3 percent, and ranged from 11.4 percent to 18.0 percent. The national government levies several taxes (the most important being a progressive income tax) and provides funding in form of top-up grants to both country councils and municipalities.

The upper limit of all direct taxes, i.e. county council, municipality and national taxes, is currently set at 52 percent. Tax rates differ across county councils and municipalities, but equalisation schemes financed by the national government are in place to balance the burden of costs across regions in Sweden. In general, such schemes redistribute funds between the rural North and the more urban South. For 1991 and 1992, the payroll tax rates for county councils and municipalities have been frozen by government decree.

The distribution of income according to source in 1989 for county councils and municipalities was as follows:

County Councils	Income Source (Percent)	Municipalities
66.7	Tax Revenues	47.0
6.1	User Charges	18.0
6.1	Tax Equalization Grants	4.0
3.0	State Grants for Special Use	21.0
11.1	Health Insurance Reimbursement	0.0
7.0	Other	10.0
100.0	**TOTAL**	**100.0**

Source: The Swedish Institute (1991), Local Government in Sweden

Local government expenditure in Sweden in 1989 amounted to SEK 341 billion ($38.5 bn 1990), or 28 percent of gross domestic product. The municipalities accounted for 65 percent, and the county councils for the remaining 35 percent.

Health care expenditures of the National Social Insurance Board are financed on a regional basis through payroll taxes, paid by the employer, and through state grants, allocated to insurance board through a weighted capitation scheme. Payroll taxes amount to 85 percent of the total income of the national insurance scheme with state grants covering the remaining 15 percent. These grants are allocated to regional insurance boards on the basis of a weighted capitation scheme.

The level of the payroll tax contributions are determined annually by the national parliament. It is set as a flat percentage of wages and salaries, currently at 9.4 percent. There is no upper limit to contributions. Because the contribution rates are determined centrally, there are no divergences in premiums across the 26 regional social insurance funds which administer the system through their regional offices.

There is a relationship between the funding of the National Social Insurance Board and the county councils. It is as follows. The National Social Insurance Board receives payments from payroll taxes and government grants. From this budget, the Board basically has to cover two main types of expenditure:

- Benefits in cash to the insured. The payments are made through the 26 regional offices.

- The National Social Insurance Board also reimburses private physicians doing full-time private work, as well as salaried physicians doing part time private work.

Because the latter type of expenditure varies over time, not least because county councils themselves decide on the level of private work which is to be undertaken in

any given year, the reimbursement scheme linking county councils and the National Social Insurance Board is as follows:

- The National Social Insurance Board pays out benefits in cash to those who are entitled to it.

- The remaining surplus is distributed to county councils, according to a weighted capitation formula. This entitlement constitutes a hypothetical entitlement budget.

- From the hypothetical entitlement budget of a council for a financial year the National Social Insurance Board then deducts the expenditure which it has spent on private physicians of the particular council in the previous year. The balance constitutes the actual entitlement budget.

Potential deficits of the National Social Insurance Board, or of the county council budgets, have been dealt with in the past by increasing tax rates. However, in the last three years the county councils have been put under increasing pressure to limit their spending. In 1988, the national parliament passed a law prohibiting any increase in their tax rates during the period of 1990 to 1992. An extension of this law to apply to 1993 is currently under discussion. In the view of some observers, the resulting cash constraints have led to an improvement in efficiency and productivity.

1.3.3.4 Regulation of the Payers

County Councils carry out their responsibility through a political decision making process, not through detailed regulations which are written down as laws. They have thus considerable freedom in the way they organise the provision of health care services within their boundaries.

The internal organisation of county councils is as follows. Each regional parliament meets several times during the year, usually in Spring and Fall. According to the constitution, regional parliaments should convene at least four times a year. Nearly all members of the county councils are also members of a political party. The regional parliament elects an executive Health Service Board of full-time councillors to administer the county council's health care service. Councillors are professional politicians. The number of people on the Board varies across county councils; on average it consists of fifteen to twenty members.

The National Social Insurance Board appoints the directors to all 26 regional offices, while the county councils elect other members of the regional social insurance board. The regional offices, however, are not under the authority of the central National Board. In fact, they perform the function of a local sickness fund. Anyone dissatisfied with a decision of a regional office can appeal to an insurance court (*Försäkringsrätt*).

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Detailed regulations exist with regard to social insurance, in particular what people with no incomes, or those who are unable to contribute to their funds, should receive in benefits. Usually people with no income are entitled to the benefits in kind provided by the county councils, but not necessarily to the benefits in cash provided by insurance funds.

1.3.3.5 Economic Incentives

County councils have a total budget which they cannot exceed because they are now not allowed to raise the taxes beyond the level set by national government. Furthermore, the administration of county councils is in the hands of elected politicians. Their incentive must therefore be to provide an adequate level of health care within the available budget.

County councils are not responsible for reimbursing physicians for the full-time or part-time private work which they allow them to do. As the cost of this work will be deducted from the budget which they receive in the following year, they have only a small incentive to allow an undue increase in the volume of private work.

Neither the county councils nor the 26 regional insurance boards of the national insurance system compete. This is because membership of county councils and regional insurance funds is determined by the fund members' place of residence. Furthermore, in the case of the insurance boards, the benefits in cash which they distribute, as well as the contributions which they collect, are both determined centrally by the national government. There are hence no variations.

1.3.4 Primary Health Care Sector

1.3.4.1 Roles and Objectives

There is no strict division between the primary and the hospital sector in Sweden. This is most clearly visible by the fact that the large majority of primary physicians, as well as most clinicians, are salaried employees of the county councils. Primary physicians have to treat all patients whose residence is within the county council borders.

Primary physicians usually work in public health centres. Public health centres are group practices with a number of doctors specialising in different fields, e.g. paediatricians, gynaecologists or psychiatrists. They also run mass health screening programs, such as health check ups for children, vaccination services, screening for cancer or mammography. Home visits, especially to the elderly, are usually made by district nurses, but seldom by physicians.

Because the health centres are often set up as group practices, an individual patient is not guaranteed to see the same doctor on each visit. Furthermore, patients can present themselves to hospitals for treatment without first being referred there by their primary

physician. Hence, the concept of a 'family doctor', common in many countries, is largely non-existent in Sweden, although nowadays the concept is highly debated, and proposals have been made by the government to move towards a family doctor system.

Approximately five percent of primary physicians (1,000 out of 20,000) work full time in private practice. Apparently they account for a much larger share of ambulatory visits by patients. In contrast to the salaried county council physicians, private physicians are paid on a fee-for-service basis by the social insurance fund. Some also have contracts with county councils to provide care for patients within the council territory. Private practitioners usually can use support services, such as pathology tests or X-rays free of charge from the nearest hospital.

There are approximately 10,000 dentists in Sweden. About fifty percent of dentists are private dentists. In general, the distinction between a private and a salaried dentist is the same as in the case of physicians. The reason, however, why the share of private dentists is comparatively high is the fact that the county councils only pay for dental care of children up to age nineteen.

1.3.4.2 Patient's Choice within the Primary Health Care Sector

Patients have free choice of their general practitioner within their county of residence or neighbouring counties; in some cases up to five. Physicians can, theoretically, refuse to take on patients, but rarely do so. Rather, if demand for their services increases rapidly, they may apply for permission from their employer, the county council, to undertake private part-time work.

The freedom of primary physicians to refer patients to hospitals is limited. Doctors are usually required to refer patients to designated hospitals within the county. If a condition requires treatment in a regional hospital outside the county's territory, the patient must be seen by a specialist in the county hospital before he or she is further referred to a regional hospital.

Patients pay a standard copayment rate set by each county council for ambulatory services. On average the copayment rate is SEK 100 ($9.18 1990) per visit. The copayment rate for treatments such as physiotherapy, occupational therapy or speech therapy is around SEK 50 ($4.59 1990). The copayment rate for a visit to the District Nurse is on average SEK 35 ($3.21 1990). For a visit to a private physician the patient may pay the same as for a salaried physician, or more, up to SEK 140 ($12.85 1990) per consultation.

1.3.4.3 Funding of the Primary Health Care Sector

As far as the funding of physicians is concerned, one needs to distinguish between salaried and private physicians. Salaried physicians receive an annual salary from the county councils.

Private physicians are reimbursed by the National Social Insurance Board on a fixed fee-for-service schedule. The fee schedule is negotiated by the National Board with the Swedish Medical Association. The national government has to agree to the schedule, and decides in case of disputes. The fees are calculated according to groups of services and numbers which define the degree of specialisation of the physician. Group and number are then translated into monetary values.

Private physicians earn slightly more than employed physicians, as they have more opportunities to expand work and influence their salaries.

Patients pay user charges for primary physician visits, but these may vary across counties. The copayments are made to the county council, not the physician. In practice, patients pay a 'cashier' prior to the consultation with the doctor.

Dentists are reimbursed on an established scale of charges. For a course of treatment, patient copayment rates are 60 percent of the costs up to SEK 3,000 ($275 1990); 50 percent of the cost between SEK 3,000 and SEK 7,000 ($275 - 643 1990); and 25 percent above that. Dentists are reimbursed by the social insurance office. Children and young people are entitled to free care from salaried dentists up to the age of nineteen.

1.3.4.4 Regulation of the Primary Health Care Sector

In order to obtain a licence as a physician, Swedes have to study medicine at a university for at least five to six years, followed by a 21 month internship in a hospital. Admission to medical departments at universities is restricted with the average grade of the final school examination determining entry. Qualification as a specialist requires another four to six years of postgraduate training. A licence to become a physician is given automatically after training and internship by the National Board of Health and Welfare. However, additionally, physicians must apply for appointments with a county council. They appoint physicians according to health care needs.

The number of physicians allowed to set up a private practice is controlled by the county councils. Their number varies across counties and is adjusted annually, depending on the need for the provision of additional primary services, if, for example, waiting lists for ambulatory services start to build up. Also controlled is the number of patients which a private physician is allowed to treat. Again the number varies across counties; at present, the average is 6,000 patients annually. Patients who are prepared to pay the full price of treatment directly to their physician are excluded from the 6,000 patients a year rule. Frequently, at the end of the financial year, doctors seek to re-negotiate with county councils the upper limit of patients they are allowed to treat.

Part time 'private' work by salaried physicians is regulated, and county council approval to do so is needed in most cases.[14] For county councils the authorisation of private work by salaried physicians, either part-time or full-time, allows them to regulate the number and flow of patients, and to reduce waiting lists.

1.3.4.5 Economic Incentives

Salaried physicians, who do not undertake private additional work, do not compete. To the extent that they are granted permission to do part-time private, i.e. fee-for-service, work, they do compete. It is, however, a relatively weak form of competition, because scope and duration of private work is highly regulated by the county council and reviewed every year. Private physicians, on the other hand, compete for patients.

1.3.5 Hospital Sector

1.3.5.1 Roles and Objectives

There are approximately 100 acute hospitals in Sweden. In addition, there are about 240 nursing homes, 130 health centres with nursing homes, and 20 psychiatric hospitals. In total these hospitals provide 116,000 beds.[15] The number of hospital beds is relatively high, standing at approximately 13 per 1,000 inhabitants, of which 4 are general acute, 2 are psychiatric and 6 are long term. The comparable figure average over the countries included in this study is approximately 9 per 1,000 inhabitants.

Sweden is divided into six medical regions with approximately 1 to 1.5 million inhabitants. The boundaries of medical regions contain those of county councils (with one exception). Each medical region has one medical school, and these are Uppsala, Lund, Stockholm, Göteborg, Umeå and Linköping. Nine large regional hospitals are affiliated to the medical schools. At present, some 900 medical students are accepted each year.

Regional hospitals are administered by the County Council where they are located, but funding comes from all those (neighbouring) counties which refer patients to the hospital in significant numbers. County hospitals, on the other hand, are less specialised than regional hospitals. Each county has at least one county hospital. They often have approximately 1,000 beds and 15 to 20 specialities. Finally, at the health district level, there are the district hospitals which are less specialised than the county hospitals.

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14 'Private' work by salaried physicians is not rare. In 1984, 16.9 percent of all salaried physicians were part-time private practitioners, compared to 7.8 percent in 1975.

15 Spri (1987), p. 10.

There are two private hospitals groups in Sweden. One is based in Stockholm where it owns several hospitals and one is based in Göteborg. They require accreditation by the National Board of Health and Welfare, which also inspects them. Public hospitals are owned by the county councils and do not require a licence.

There is a small nursing home sector, which is private. Often, such homes are run by families on a non-profit basis, providing care for the mentally ill, alcoholics, or drug addicts. The owners are reimbursed by municipalities. There are, in general, no queues for admission to long-term care institutions, mainly because the municipalities have set up various arrangements, from home nursing to communal group dwellings, for the elderly.

1.3.5.2 Patient's Choice within the Hospital Sector

Patients have free choice to which hospital they refer themselves to or, in consultation with their primary physician, are referred to, as long as the hospital is within the territory of the county of residence. If patients are referred to hospitals outside their county of residence, then cross boundary payments are made between the counties of their residence and the counties of their treatments. Often, county councils have reciprocal agreements for cross boundary flows, in particular in rural areas, where adequate care may not be available in the immediate vicinity of patients' residences.

Copayments for outpatient visits to hospitals vary across counties, but are on average SEK 100 ($9.18 1990). For inpatient treatment, the average copayment is SEK 70 ($6.43 1990) per 24 hours which is deducted from the sickness benefit which patients receive. Pensioners pay at most SEK 65 ($5.97 1990). Copayments are set by the county councils.

1.3.5.3 Funding of the Hospital Sector

Hospitals are reimbursed through annual budgets paid by county councils which include the costs of all staff, (including clinicians), drugs, medical supplies and other items. Operating costs are separated from investment costs in most, but not all, county councils. County councils regulate the expansion of hospitals through the increase in their global budget.

Funds are allocated from county councils to health care districts, and from there to individual units and departments. The general method for allocating funds is that of global budgeting, although this now gradually changing. Several county councils are at present introducing alternative ways of financing and delivering health care. We briefly introduce two such models.

Under the **Stockholm Model**, Stockholm county council (with approximately 1.7 million people) aims to increase the effective utilization of the county's resources. The new model started in January 1992, but is not expected to be fully implemented until 1995.

Under this model, Stockholm will introduce an internal market for hospital services. A local purchasing authority will buy services on behalf of the population within its boundaries. Hospitals will be paid according to the services they provide. Diagnosis Related Groups (DRGs) will serve as output measures. Patients will be free to choose their primary physician, as well as their hospital. In January 1992 ceiling prices were announced for general surgery, obstetrics and gynaecology, urology, orthopaedics and cataract surgery, but they do not come into effect as effective maximum prices for hospitals before January 1993.

Under the **Dalamodel**, the Darlarna region aims to create a mixed public/private market for health service providers, whereby public as well as private providers will be able to compete for funds to provide care. Under the Dalamodel, it is also intended to devolve all primary and hospital care funds from county councils to district boards, who will then act as purchasers of health care. These purchasers will negotiate health care contracts with the local providers. Citizens will be able to select whichever health care centre they prefer. This choice includes health centres outside their area of residence. If they choose an outside health centre, then this centre is reimbursed through cross boundary payments from the home district board. Patients will, however, be required to accept referral to a hospital within their home district whenever possible.

The following table gives an indication of the average costs per bed-day for different medical departments in Swedish hospitals:

Type of Ward	Costs per Bed-Day SEK 1985	$1990
Medicine	1,200	169
Surgery	1,900	268
Neurosurgery	4,300	606
Cardio-thoracic Surgery	5,600	790
Paediatrics	2,500	353
Maternity	2,000	282
Psychiatric Care	1,300	183
Long-Term Care	800	113

Source: Swedish County Councils (1989), p. 14.

During the period of expansion in the fifties and sixties, hospitals were usually compensated for budget deficits. The difficulties of hospitals in keeping within their budgets led to the development of tighter overall cost controls combined with a decentralised system involving clinical budgeting. Clinical budgeting means that the

clinical heads which lead the clinical departments are also responsible for the global budgets of their departments, which are generally divided into operating and investment costs.

1.3.5.4 Regulation of the Hospital Sector

Some health care experts in Sweden express a strong belief that the financing of Swedish hospitals through global budgets has been, by and large, successful. Although waiting lists existed for the treatment of some mainly non-acute ailments, e.g. hip replacements, cataract operations, and coronary by-pass surgery, these waiting lists are not excessive. Recently the government has promised to guarantee treatment within three months for certain of these specialties, and county councils were encouraged to implement this guarantee by granting cost-per-case payments in addition to the agreed hospital budgets. The new regulations have helped to reduce waiting lists significantly in the past year.

In the opinion of health care experts, the existence of waiting lists points to a management problem due to planning rigidities, not a resource problem. It also seems to be the case that waiting lists are defined rather crudely. In particular they may not always indicate unmet needs of the Swedish population.

Since 1991 municipalities have been responsible for the long term care of the elderly. Previously that responsibility lay with the county councils. In the course of the transfer of responsibility for long-term care patients, a tax switch between county councils and municipalities took place. It is anticipated that by shifting the responsibility to the lowest level in the health care system, more innovative ways of care for the long-term patients can be found, which will eventually reduce the expenditure for the care of the long-term ill. There is some evidence that municipalities do use a variety of ways for caring for the long-term ill and elderly. This includes the involvement of self-help groups, neighbourhood care schemes or district nurses making home visits.

1.3.5.5 Economic Incentives

In general, hospitals do not compete, since they are financed through global budgets which are often determined on the basis of last year's budget. The situation is changing, however, with the government's drive to cut down waiting lists on some specialties. To achieve this, payment schedules have been altered to allow for cost-per-case payment for those specialties where waiting lists exist or unmet need is suspected. This change in payment schedule has set an incentive for hospitals to compete for the additional work, especially in urban areas such as Stockholm. It is argued that the introduction of cost-per-case payments will have a significant effect on productivity in Swedish hospitals. Similarly, in other urban areas such as Malmö/Lund and Göteborg there are also signs of increasing competition and corresponding patient flows between county councils and independent municipalities. Competition also exists in the very

small private market for elective surgery, which is carried out almost exclusively in private hospitals.

1.3.6 Pharmaceutical Sector

1.3.6.1 Roles and Objectives

The pharmaceutical sector in Sweden consists of the pharmaceutical industry, two wholesale or distribution companies, and one centralised retailer with retail outlets. This retail organisation is the National Corporation of Swedish Pharmacies (*Apoteksbolaget*) which is responsible for purchasing and distributing drugs. There is also a Medical Products Agency (*Läkemedelsverket*) which is responsible for drug control and registration.

Total sales in the Swedish drug market in 1988 were SEK 8,280 million ($1.0 bn 1990) in retail prices (excluding VAT). Some 174 firms were represented, of which 31 were domestic. The five largest pharmaceutical firms in Sweden - Astra, Kabi, Pharmacia, Glaxo and MSD - account for 50 percent of the market.

The market share of foreign companies has increased from 51 percent in 1978 to nearly 60 percent in 1988. For several years, Sweden has had a positive trade balance in pharmaceuticals. In 1988, for example, Sweden exported drugs worth SEK 4,767 million ($572 mn 1990) and imported drug worth SEK 2,795 million ($335 mn 1990). The share in health care costs of medicines has been fairly constant over the years and ranges from 8.1. percent to 8.8 percent for the years 1980 to 1988. Similarly, during this period the share of medicines in gross national product ranged from 0.71 percent to 0.76 percent.

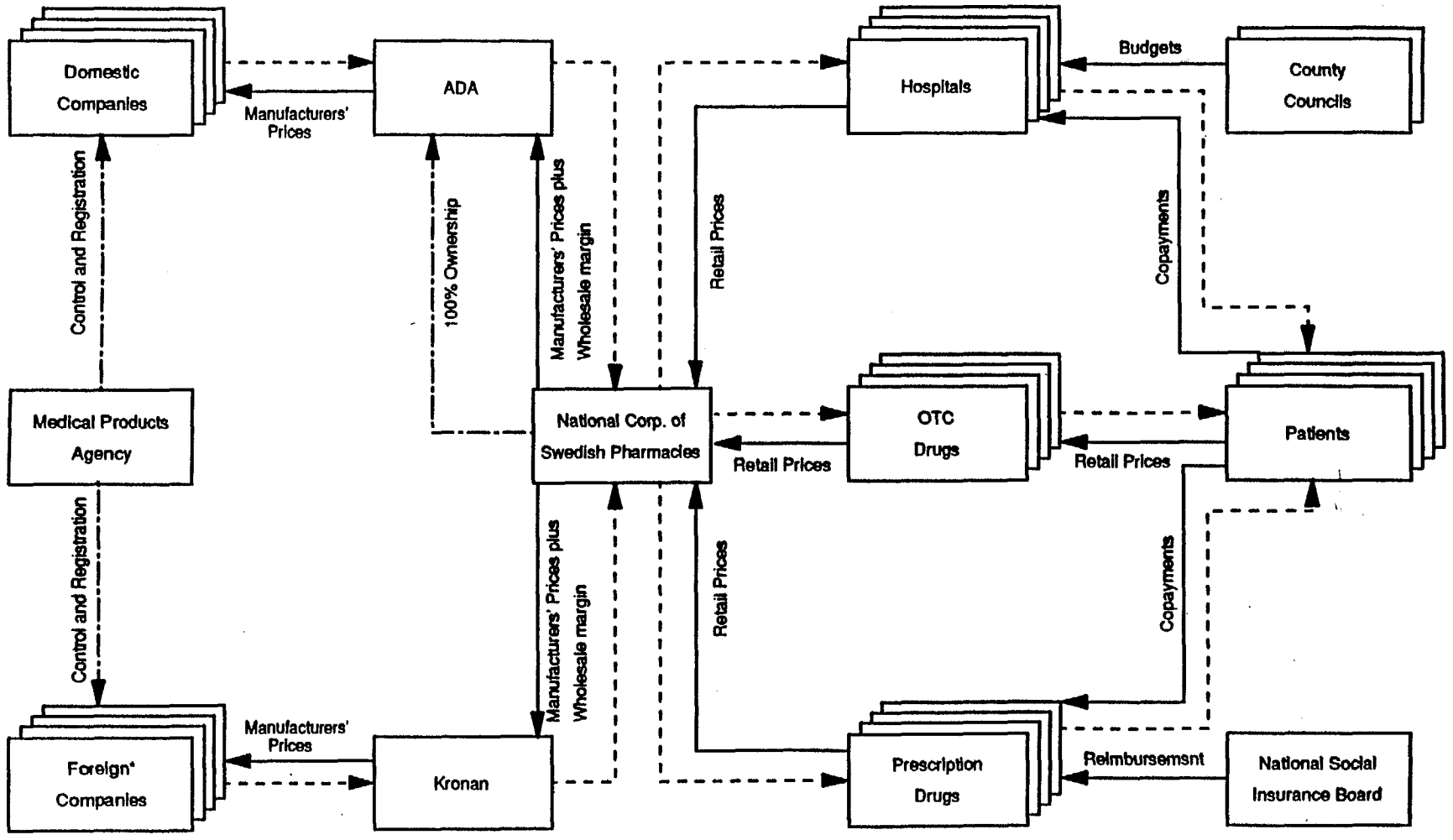
Chart 1.3 presents an overview of the pharmaceutical sector in Sweden. Production of medicines is divided between domestic and foreign producers. The bulk of medicines are distributed by two wholesale companies, *ADA* and *Kronans Droghandel (Kronan)*. *ADA* is owned by the National Corporation of Swedish Pharmacies, while *Kronan* is owned by a consortium of foreign producers.[16]

Almost all retail sales are controlled by the National Corporation of Swedish Pharmacies (*Apoteksbolaget*) which acts as a retail organisation. This means that the Corporation has a monopsony in the producer market and a monopoly in the retail market. A minor part of the retailing is also managed by the National Bacteriological Laboratory (*Statens Bakteriologiska Laboratorium*), and by the National Centre for Veterinary Medicine (*Statens Veterinärmedicinska Anstalt*). *Apoteksbolaget* is owned to two thirds by the state, and one third by the pension fund of pharmacists. *Apoteksbolaget*

[16] A small amount of drugs are distributed directly from the domestic and foreign producers to the National Corporation of Swedish Pharmacies. Some foreign companies also distribute through ADA.

Chart 1.3

The Pharmaceutical Sector in Sweden



* Some Foreign Firms Distribute Through ADA

Financial Flows
Flows of Drugs
Other

itself owns the wholesale company *ADA*. It has about 825 public outlets, of which 80 are located in hospitals.

The National Corporation of Swedish Pharmacies provides drugs to hospitals and the primary care market. The use of medicines in hospitals is reimbursed by the budgets allocated to them by the county councils. The prescription market is financed by the National Social Insurance Board through the Drug Benefit Scheme, and by patient copayments. Over-the-counter medicines are financed by consumers. The relative shares of hospitals, prescription drugs and OTC drugs have remained fairly constant over the last years and are as follows:

Market Shares in 1988 (Retail prices, excluding VAT, SEK million and Percent)

1,482 ($179 mn 1990)	Hospital Market	18
6,081 ($730 mn 1990)	Prescription Market	73
717 ($ 86 mn 1990)	OTC Market	9
8,280 ($1002 mn 1990)	**TOTAL**	**100**

Source: Jönsson (1991), p. 155.

The nominal patent duration in Sweden is twenty years. Effective patent duration has decreased from 11.5 years during 1965 to 1969 to 9.6 years during 1985 to 1987.

1.3.6.2 Patient's Choice with the Pharmaceutical Sector.

Consumers have a choice of which pharmacy they go to in order to obtain medicines. Consumer copayments for drugs were set at SEK 65, but have recently (1992) been increased to SEK 90 ($8.26 1990) per prescription for the first drug, and another SEK 10 for every other drug on the same prescription; the remainder is reimbursed by the National Social Insurance Board through the Drugs Benefit Scheme (see Sub-Section 1.3.6.4). The upper limit of annual copayments, covering patient charges and drug costs will be raised by SEK 100 to SEK 1,600 (to $147 1990) as of 1 January 1993.

1.3.6.3 Funding of the Pharmaceutical Sector.

Prices of drugs are decided in negotiations between the National Corporation of Swedish Pharmacies and the producer.[17] This position as a monopsony buyer, and effectively a price regulator, gives the Corporation significant market power, which it appears to have exercised in recent years. Price increases have been lower for

[17] New reimbursement rules are to be introduced in January 1993 (see Part 4).

medicines than for consumer goods in Sweden throughout the eighties. Drug prices are also considered to be low in comparison to other European countries; only Belgium, France, Italy and the United Kingdom have lower prices.[18]

The margins of the wholesalers and the retailer (i.e. the National Corporation of Swedish Pharmacies and its outlets) for averages of sales are as follows: the manufacturers' prices to the wholesalers account for 68.2 percent of the pharmacy selling price; the wholesalers add 4.2 percent to the manufacturers' prices, which accounts for 2.8 percent of the pharmacy selling price; finally, the retailer adds 41 percent to their purchasing price which accounts for 29 percent of the pharmacy selling price.[19]

Hospitals are given a drugs' budget by the county councils. Hence, medicines which are part of inpatient treatments are reimbursed by the county councils.

Prescription drugs, which the patient purchases from retail pharmacies, are paid for partly by user-charges and partly by the National Social Insurance Board. In practice this works the following way. The National Corporation of Swedish Pharmacies submits an invoice to the National Social Insurance Board which lists the pharmacies' recorded sales during the calendar month. A division is made into the various payment categories, including those which are free of charge on account of various high-cost protection schemes. Such schemes include the SEK 1,600 rule, or other exemptions (see Sub-Section 1.3.6.4 below). The National Social Insurance Board then pays out the reimbursement sum directly to the National Corporation of Swedish Pharmacies.

Since the volume of prescription medicines purchased by patients from retail pharmacies is demand driven, the reimbursement levels from the National Social Insurance Board are open-ended.

1.3.6.4 Regulation of the Pharmaceutical Sector

At present, prices of medicines are fixed in negotiations between the manufacturers and the National Corporation of Swedish Pharmacies which holds a monopsony position with respect to the pharmaceutical industry. If agreement cannot be reached the price is set by another body, the Medical Product Agency. The price which is agreed between the two parties is the pharmacies' purchase price. It includes the reimbursement to wholesalers for distribution and storage. The pharmacies' selling price is also set by the National Corporation of Swedish Pharmacies. It is same throughout the country. The difference between purchase price and selling price makes up the Corporation's margin. From that margin it has to cover the costs of running the

[18] Jönsson, B (1991), p. 160.

[19] The Association of Representatives of Foreign Pharmaceutical Industries (1991) p. 19.

country's 825 pharmacies and its own administration. It must also cover the annual dividend requirement of the Corporation which amounts to 6 percent of its capital.

In June 1992 the national parliament decided on various changes to the reimbursement scheme for pharmaceuticals. The first set of changes relate to copayments for patients. These changes came into effect in July 1992. The second set of changes proposes the introduction of a reference price system, planned for January 1993. Both changes are explained below.[20]

The old regulations concerning copayments for pharmaceuticals were as follows. For each prescription-only medicine there is a maximum charge to the patient of SEK 90 for each item on the prescription. The costs which exceed that amount are paid by the National Social Insurance Board. For those suffering from long-term and serious illnesses medicines are free of charge, if the government has determined that the illness gives entitlement to exemption from charge.[21] The regulations meant that each person paid a fixed charge of at most SEK 90 for each purchase, regardless of how many medicines were on the same prescription issued by the doctor, and irrespective of how expensive they were.

From July 1992, new regulations are in place. The patient pays a maximum copayment of SEK 120 for the first item of the prescription. For each additional item which is purchased at the same time, the copayment will be SEK 10. In this event, the copayment of SEK 120 is to be made on the pharmaceutical preparation which has the highest price.

The government estimates that this new measure will reduce the net expenses by the National Social Insurance Board by approximately SEK 400 million a year.

The second change is a reform of the present method of prices control for drugs. Here, the government has made the social insurance system responsible for the setting of prices of medicines. The main reason for this change is to make Sweden's new reimbursement scheme compatible with the legal rules of the European Community which Sweden is obliged to follow as part of its application for membership of the Community.

The rules are as follows. Reimbursement levels for medicines will be set by the National Social Insurance Board. In the view of the Swedish government, the EC Transparency Directive [89/105/EEC] on drugs specifies that price controls for medicines cannot be linked to the registration procedure of drugs, as is currently happening in Sweden. However, according to the Swedish Minister of Health, it is not

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20 The changes in the reimbursement scheme for pharmaceuticals as proposed by the government is based on a Government Bill 1991/92:151, and on extracts from the minutes of a ministerial meeting on 26 March 1992. See also: Jendteg, S (1992) pp. 2-3.

21 Exemption of charge also applies to prophylactic medicine for pregnant women and for children.

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possible to do without some form of price control if the aim of limiting the costs of pharmaceuticals is to be realised. Hence, a new price fixing system is required. As of January 1993, drug manufacturers have to make an application to the National Social Insurance Board requesting that the pharmaceutical product be covered by the benefits system, and that therefore the patient receives a price reduction. It is then the responsibility of the National Social Insurance Board to decide whether the medicine will be included in the list of products covered by the benefit scheme, and at what reimbursement level. For the latter decision, the Insurance Board may be assisted by the National Corporation of Swedish Pharmacies.

While essentially this means that pricing of drugs is free, the reimbursement levels are in fact not. As a further regulation, the government also decided that for each pharmaceutical preparation for which there is an equivalent but cheaper counterpart on the market, the reimbursement levels should be based on the price which was set for the cheapest equivalent preparation plus 10 percent. If a consumer opts to purchase a different, more expensive equivalent preparation, then they will have to pay the difference between the price of the branded product and the reimbursement level of the cheaper equivalent themselves. Equivalent counterpart is defined hereby as "a pharmaceutical preparation which has the same physical form and contains the same quality of active agent as a previously registered pharmaceutical preparation with documented medicinal expediency".[22] A further requirement is that the patent term for the brand-name product has expired, and that there is at least one generic counterpart on the market.

The new reimbursement scheme for drugs in Sweden is similar to the system of reference prices introduced in Germany in 1991, in particular to the so-called Stage 1 of the system which covers medicines with therapeutically equivalent active substances.[23] As a result of the introduction of the reference price system in Germany, many manufacturers' prices for medicines converged to their reference price levels.

1.3.6.5 Economic Incentives

The budget restriction under which hospitals work means that they are likely to be cost-conscious when they purchase drugs. Each hospital has a drug formula committee that makes recommendations on drug purchases within the restricted hospital budget. The budget restriction means that hospitals choose carefully which drugs they purchase. However, individual clinicians may not have a strong incentive always to use drugs efficiently, unless they manage their own budgets, as is usually the case in Swedish hospitals.

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22 Government Bill 1991/92, Annex: extracts from the minutes of a ministerial meeting on 26 March 1992, p.23.

23 Stage 2 of the German system covers medicines with pharmacologically comparable active substances, especially chemically related ingredients, while Stage 3 covers medicines with pharmacological-therapeutic effects, particularly drug combinations.

Prescription drugs have the largest share of the Swedish retail market (73 percent). In this market, the incentives for the consumer as well as the prescribing doctor to be price-conscious are relatively weak. Consumers only have an incentive to be cost-conscious up to the copayment which they pay. However, the fact that patients pay a copayment rate for each visit to a physician may act as a deterrent to drug consumption. Fewer visits to physicians may take place than would be the case in the absence of physician visit copayments. This may result in lower levels of medicines being prescribed and consumed.

Physicians have no incentives under the present system to take cost-effectiveness criteria into account when prescribing drugs.

1.3.7 Other Participants

The National Board of Health and Welfare (*Socialstyrelsen*) is a relatively independent administrative agency. It employs approximately 300 people and has a central office in Stockholm as well as five regional offices. Its tasks include:

- supervising, monitoring and evaluating developments in all areas of health care; and,
- providing expertise and advice in the field of health care to the government.

The National Board of Health and Welfare generally assumes the role of a watchdog on issues such as quality control checks. It undertakes these on a regular basis in all county councils. From time to time, it also performs detailed investigations of a single county council to assess the service quality and cost-effectiveness of the primary sector, of hospitals, and of the social services. Such detailed investigations may last up to six months. Additionally, the National Board is responsible for the licensing of physicians and private hospitals.

The National Institute for Planning and Rationalization of Health Services, or SPRI (*Sjukvardens och Socialvardens Planerings och Rationaliseringsinstitut*) works on planning and efficiency measures, undertakes special investigative tasks and carries out applied research on health care. It is owned and funded jointly by the Government of Sweden and the Federation of County Councils.

Another national organisation is the Swedish Council of Technology Assessment in Health Care (*Statens Beredning för Utrardering av Medicinsk Metodik*, or *SBU*). The Council is charged with a number of tasks. They include the identification of new or established medical technologies needing assessment; the establishment of medical, economic, humanitarian, and social values of using different technologies; the promotion of the rapid introduction of new medical technology which replaces less effective methods; the information of interested parties about the outcome of

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technology assessment activities; and the monitoring and reporting on international studies and developments.[24]

Misconduct of health care personnel is investigated by the National Medical Disciplinary Board (*Hälso-och Sjukvardens Ansvarsnämnd*).

[24] Stocking, B. (1992), p. 28.

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1.4 INTERSECTORAL ANALYSIS

1.4.1 Major Decision Makers

During the last three decades, the Swedish health care system has undergone a decentralisation process that has progressively accelerated during the last few years. Consequently, health care policies have increasingly been formulated at the regional, county council, level. Similarly, health care reforms are implemented almost exclusively at the county council level.

This suggests that the most important decision makers in the Swedish health care system are the elected members of the boards at county council and district level since they are responsible for the implementation of health care policies. They are staffed by members of the Swedish political parties. Many county councils, as well as the Federation of County Councils, are nowadays governed by coalitions of non-socialist parties. The Social Democratic party is still the largest political party, and retains some influence through its strong affiliation to the Swedish trade unions.

The Federation of County Councils, which is only a loose association, at first appeared to support this drive towards decentralisation. It saw its major role as issuing unifying guidelines on health care policy matters, thus exercising a strong, but indirect, influence over health care policies in the counties.

The result, however, has been that some counties, especially those which are busy experimenting with new forms of resource allocation in health care, have been increasingly less willing to be guided in their reform drive by the Federation in Stockholm. As a consequence, the Federation has lately lost much of its influence over health care policies.

At the national level, various reform proposals have been suggested, which aim to overhaul the entire health care system to varying degrees (see Section 1.5). Some more radical suggestions are likely to require the national parliament to pass new legislation, since the funding mechanism of health care would have to be reformed.

In the meantime, however, the county council authorities, which still act as providers and purchasers of health care, are experimenting with ways to locally reform the organisation of health care. These reforms seem to be guided by two principles:

- Health care policy reforms in most, but not all, county councils are marginal and progress only slowly.

- To a large extent, these reform policies aim to introduce some elements of market mechanisms into a largely budget-controlled system without compromising on the quality of health care.

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1.4.2 Consistency of Objectives and Incentives

The demarcation of central and local responsibilities for health care leads to potential conflict. For example, at central level, the National Board of Health and Welfare and the Federation of County Councils have overlapping responsibilities as far as planning of health care is concerned. This means that it is possible that both organisations may issue guidelines, say, on matters relating to quality of health care, which are potentially contradictory.

Both organisations, but in particular the Federation, have yet to come to terms with the decentralisation of the Swedish health care system. As individual county councils assume more independence from the centre, they are increasingly less likely to respond to directives from Stockholm. The erstwhile strong influence of the Federation, which led it to be called the 'unofficial Ministry of Health', has recently vanished. The Federation is at present re-evaluating its role in the new decentralised Swedish health care system.

Similarly, on the local level, the demarcation of responsibilities between municipalities and county councils has not always been clear. Both organisations have an incentive to shift responsibility for care, and hence for financing care, onto each other. This happens often with those aspects of health care which are closely connected with the social services, e.g. psychiatric care, or drug user rehabilitation.

Furthermore, there is a marked absence of incentives for most key participants to improve efficiency. However, efficiency seems to be improved on the occasions on which economic incentives are introduced into the system. For example, in January 1992 the national government and the Federation of County Councils agreed to reduce the waiting times for certain treatments and operations to no more than three months. The ailments covered by this rule are coronary artery disease, hip-joint and knee-joint replacement, cataract surgery, gallstone surgery, hernia surgery, surgery of prolapse and incontinence, and hearing aids. If patients cannot get treatment within the specified time period, they have to be offered treatment in another county or in a private hospital. Hospitals are paid for this on top of their existing budget. Early evidence suggests that waiting lists have been reduced significantly.

1.4.3 Economic Implications for Efficiency and Equity

In general, social or class related differences in mortality or morbidity are much less pronounced in Sweden than in many other countries. Material resources and living conditions are more equally distributed in Sweden, due to general policies in the last decades which have strongly favoured redistribution. The general welfare and redistribution policies implemented in the last decades by a predominantly social-democratic government were facilitated by continuous growth in gross domestic product. Only recently has growth slowed down and made such policies more difficult.

There are, however, inequalities in some areas of the Swedish health care system:

- Hospitals show considerable differences in terms of quality of care, and in terms of productivity and efficiency. A national project initiated in 1990 by parliament, called the **Dagmar 50** project, aimed to compare resource use and productivity across hospitals for various specialties, such as medicine, surgery, orthopaedics, gynaecology, urology and ophthalmology. The review pointed to extensive differences between the hospitals analysed. The project also suggested that, in order to improve capacity utilization, planning and organisation of hospital care should be made more flexible, and day surgery should be encouraged.

- There are regional imbalances in the provision of service across county councils. The availability of medical specialists is lower in the provincial and rural areas of the North than in the more densely populated areas in the South.

- The use of sickness benefits is also significantly higher among blue-collar workers than among white-collar workers and professionals.

The main weaknesses of the Swedish health care system leading to inefficiencies are considered to be:

- There is a lack of integration between health services, social services and health insurance, and between primary and hospital care. Primary care physicians do not act as gatekeepers which results in a high proportion of self-referrals to hospitals by patients. This emphasis on institutional care largely has a historical basis. In the fifties and sixties much emphasis was put on hospital care with a tendency towards concentrating acute services in a limited number of units with a large number of beds.

- There is a lack of responsiveness to consumer preferences. The position of the consumer seems to be relatively weak, due to the absence of family doctors who would ensure continuity in patient-doctor relations, a lack of choice of hospitals, occasionally long waiting lists or waiting times and inconvenient opening hours of primary physician practices. These shortcomings are particularly important at a time when social thought and policy is becoming more market-oriented.

- There are significant differences in productivity of hospitals and in the quality of the services provided by them.

1.5 ANALYSIS OF HEALTH CARE POLICY

1.5.1 Current Health Care Policies and Proposals

Swedish health care policies over the last three decades have concentrated on the decentralisation of the health care system. In 1963 responsibility for primary care was passed to the county councils; in 1967 responsibility for mental illness institutions was transferred to county councils; and in 1982 the county councils were put in charge of health promotion and public health, including public vaccination programmes through a new Health Care Act. In 1982 and 1983 the two university hospitals still owned by the State at the time, the *Karolinska* Hospital in Stockholm and the *Academic* Hospital in Uppsala were put into the ownership of county councils. Recently, in 1991, responsibility for long term care of the elderly was passed from county councils to municipalities, thus further decentralising the system.

As a consequence of the now decentralised system, it is difficult to assess reform of the entire Swedish health care system. A national reform policy is not implemented at present, and indeed does not exist. What does exist is several proposals concerning how to reform the Swedish health care system. These proposals come from two main sources, namely the Federation of County Councils, and the Ministry of Health and Social Affairs. We will deal with each in turn.

The first group of proposals was published in a report published by the Federation of County Councils in 1991 under the name 'Crossroads - Future Options for Swedish Health Care'. The report presented the findings of a group of experts from the Federation, the Ministry of Health and Social Affairs, the National Board of Health and Welfare, health economists from universities, and administrators from county councils and municipalities. The project was initiated in 1988 by the Board of Directors of the Federation of Swedish County Councils.

The Crossroads report proposes three models of health care reform in Sweden:

- **The National Model**
  Under the National Model, financing of health care would become the responsibility of a national insurance fund. The fund would receive its resources from national payroll tax. The fund would provide finance for benefits in kind as well as benefits in cash. County councils and municipalities would lose their right to levy taxes on their citizens for services which would then be covered by the national fund. Parliament would determine the fund's resources once a year, and would also decide on fees and benefits.

  Responsibility for financing health care would be separated from the responsibility for providing health care. To accomplish this, the providers would sign contracts with the fund. Contracts would determine volumes and

prices of different services. Citizens would have the right to choose any provider in Sweden which had a contract with the national fund.

- **The Coordinated Model**
  The coordinated model splits the responsibility for children, youth and the elderly, from the responsibility for people of working age.

  Municipalities would be responsible for the provision of all health care services to children, youth and the elderly. In effect, the municipalities' obligation to provide care would commence with birth and continue until the child reaches legal age. It would then re-commence when the individual reaches retirement age. Municipalities would finance their activities through income taxes and patient fees. They would purchase health care from providers by concluding contracts. These provider institutions would either be owned by municipalities (e.g. nursing homes), or, more likely, would be owned by county councils.

  Responsibility for health care for people of working age would be transferred to a national insurance fund. The fund would finance its activity through a payroll tax. It would be responsible for benefits in kind as well as benefits in cash. Regional insurance offices would contract for health care services with different providers, e.g. hospitals and primary care centres.

  Municipalities and regional insurance offices would closely coordinate their activities. Patients of both groups would have the right to choose any provider with which their insurance office had a service agreement.

- **The Population Based Model**
  Under this model, the county councils would be abolished and Sweden would be divided into eight (medical) regions. Each region would have between 1 to 1.5 million inhabitants. The regions would be solely responsible for financing health care. They would finance their activities through payroll taxes and patients' fees. Regions' opportunities to tax their citizens would be regulated by the national government. The division of Sweden into eight regions would be such as to avoid the necessity for complex annual tax transfers across regions.

  Health care services would be provided by regions themselves. They would have considerable independence and freedom in the way they organise the health care system. This might include the possibility of regions signing contracts with providers or even with private organisations. Patients would enjoy freedom of provider choice, but only within their region of residence.

The Federation of County Councils submitted its proposals to the public in 1991. Also in 1991, Sweden held elections. At the national level, a new conservative led government was elected, ending nine years of social democratic governments. Soon

afterwards, the Ministry of Health and Social Affairs of the new government announced that it would conduct a new review of the Swedish health care system.

In March 1992 the Swedish government appointed a parliamentary committee "to present an analysis and assessment of the funding needs of health services and medical care and the way in which those needs could be provided for until the year 2000, within the framework of a national economy in balance".[25] The remit for the committee includes putting forward one or more proposals concerning the future funding and organisation of health care services and medical care, and in this connection, should also assess the developments of health care systems in the Nordic countries, Germany, Britain, the Netherlands and Canada.

Furthermore, the Committee's recommendation are to be based on the analysis and evaluation of three models of funding and organisation. All three models are to be based on the assumption that funding is derived almost completely from taxation revenue, from social security contributions or from compulsory insurance premiums. The level of any such premium would be set according to payment capacity, rather than the individual's health cost. The proposal regarding funding and organisation of the three models should, however, also be based on the assumption that "competition between different types of care-producers, both public and private, is generally good for productivity".[26]

The three models proposed by the parliamentary committee are as follows:

- **A Reformed County Council Model**
  The first model is based on the existing system, but would further emphasize the division between the funding role and the provider role of county councils in the present system. This would entail a clearer distinction between the county councils as the funding agency, and the primary and hospital sector as the provider organisations. In this internal market model, patients would have the right of free choice of care-provider, and payment would follow the patient. Health services could be supplied by both public and private providers.

- **Primary Care Control**
  In this model, all funding for health services would be placed into the primary care sector. Patients would be free to choose a family doctor. Doctors would be allocated a budget which is dependent upon the number of patients they see. This budget would also include the cost of specialist or hospital care which primary physicians would purchase, on behalf of their patients, from suitable care providers. This model is similar to the system of Fundholding GPs introduced in the United Kingdom in 1991.

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25 Ministry of Health and Social Affairs (1992), p. 12.

26 Ministry of Health and Social Affairs (1992), p. 18.

- **Compulsory Medical Insurance**
  This is the most radical of the three models. In it, the responsibility for the funding of health services is transferred to one or many insurance providers. Its introduction would mean abolishing the right of county councils to levy taxes for health care services. Insurance funds would be set up which would compensate providers of care according to a schedule of charges.

The evaluation of the three models should be completed by 1 March 1993. The parliamentary committee's work is to be completed on 1 March 1994.

1.5.2 Assessment of Current Health Care Policies and Proposals

The current abundance of proposals on how to reform the Swedish health care system must be seen against the background of the current general politics in Sweden. In 1991, Sweden elected a new national government which marked the end of a long period of government by the Social Democratic Party (*Arbetarepartiet-Socialdemokraterna*). The new government is a coalition of four parties: the Conservative Party (*Moderata Samlingspartiet*), the Centre Party (*Centerpartiet*), the Christian Democrats (*Kristdemokratiska Samhällspartiet*), and the Liberal Party (*Folkpartiet Liberalerna*).

The parties of the present government agreed that the health care sector in Sweden needed re-evaluation. This thinking largely stems from the fact that Sweden's already high level of public spending[27] would increase still further as more demand is placed on the health care system, at a time when the government is attempting to reduce the level of public spending. However, there is still agreement amongst experts and the public that the Swedish health care system is providing quality care to its citizens.

The government apparently could not decide on a national strategy for health, and hence decided to appoint a parliamentary committee to study the issues. The Conservative Party is said to favour a compulsory insurance scheme, along the lines of the third organisational model which the committee is to study. They are backed in this demand by the Swedish Medical Association which supports an insurance-based system, together with a fee-for-service reimbursement scheme for physicians.

The Liberal Party is said to favour a reformed global budgeting system, a proposal not considered any further by the parliamentary committee. The Liberals would also like to see the introduction of family doctors, rather than the present primary health care centres. The Secretary of State responsible for health, Bo Könberg, is a member of the Liberal Party.

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[27] According to OECD data, Sweden's share of GDP consumed by the public sector was 60.2 percent in 1989, against an OECD average of 41.2 percent. Similarly, the savings ration in Sweden in 1989 stood at 7.2 percent, against an OECD average of 8.9 percent.

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CHAPTER 1
PROFILE OF THE HEALTH CARE SYSTEM

1.1 SUMMARY

- Structure

The health care system in the United States is characterized by a mix of regulation and competition in both financing and delivery. Funding is provided through a combination of public and private sources. In 1990,[1] approximately 42 percent of health care spending was financed by government sources with the remainder coming from private insurance (33 percent), consumer out-of-pocket payments (20 percent) and other sources, such as philanthropy.

On the public side, virtually all Americans 65 years of age or older are covered by Medicare, a Federal Government program that exerts a strong influence over providers through administered prices. The elderly often purchase private supplemental first-dollar insurance called Medigap. Medicaid, a joint state and federal program, covers less than one-half of the poor, including many elderly for out-patient services.

Private insurance provided through employers covers approximately 70 percent of Americans under 65 years of age plus many retirees. Private insurance markets in the US are very competitive. This has produced innovative attempts by insurers to control excess consumption of care.

Not all Americans have health insurance coverage. In 1990, approximately 14 percent (33 million) were uninsured year round, while millions of others experienced lapses in coverage. All the uninsured must rely on charity care, pay for services out-of-pocket or go without care, while others (approximately 15 million) were under-insured.

The health care delivery system in the US is diverse and competitive. Providers are generally independent suppliers responsible for their costs and revenues.

- Aggregate Level of Expenditure

Historically, the US has financed health care through an open-ended system. Total spending depends on patient demands and needs, the prevalence of government and employer-provided health insurance coverage, the incentives

[1] 1990 data is used for most of the United States Report to facilitate comparisons with the other countries in this study.

of patients and providers in making treatment decisions and the pace of technological change. In 1990, total national health care expenditures were $666.2 billion with per capita spending on health care at $2,566. While the cost of the entire American health care system in terms of the share of Gross National Product (GNP) rose from 5.3 percent in 1960 to 12.2 percent in 1990, the share of GNP spent on prescription drugs has remained constant for three decades — 0.53 percent of GNP in 1960 and 0.58 percent in 1990. Increasing expenditures on health care have caused a growing number of third-party payers to shift their method of reimbursement to providers from retrospective to prospective payment arrangements. The purpose of these changes is to create greater cost consciousness among insurers, providers and patients.

What contributes to rising health care costs is at the center of every discussion. While the debate continues, the US Department of Commerce attributes rising health care costs to:

- the proliferation and use of expensive technology,
- higher utilization,
- innovative but costly long-term treatment for diseases such as cancer and AIDS,
- an aging population, and
- a labor-intensive health care industry.

- Incentives

Private Insurance: Insurers feel that they must avoid adverse selection[2] if their premiums are to remain low and competitive. Thus, insurers have an incentive to refuse coverage to people with a history of health losses and often spend significant resources screening potential subscribers. This contributes to one of the major problems of the US system: the number of uninsured. The least healthy people pay the highest premiums and the sickest people are often also among the poorest and unable to obtain coverage. Public opinion considers the cost of health insurance premiums to be needlessly high and biased toward the healthy. Insurers are attempting to address the problem of moral hazard through coinsurance and innovations in managed care.

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2. Adverse selection occurs when a patient has knowledge about a medical condition he may already have (or be disposed to because of genetics), but keeps that knowledge from the insurer who is underwriting an insurance policy with a premium that is not rated for the risk of his pre-existing medical condition (or predisposition).

Physicians: General practitioners and specialists are paid under a variety of arrangements, including fee-for-service, salaries or, increasingly, capitation and other risk-sharing arrangements found in managed care contracts. Traditional fee-for-service payment arrangements often encourage physicians to provide high-cost care, which can also be of low-benefit. In a managed care environment, the role of the primary care physician as gatekeeper to the specialist and hospital sectors is growing in importance. Risk-sharing payment arrangements encourage primary care physicians to be cost-conscious, but may also raise issues of quality of care.

Hospitals: Hospitals, like physicians, are paid in several ways with an increasing emphasis on prospective pricing. Increasingly, funds come from a fixed payment per diagnosis, such as the diagnosis related groups (DRGs) under Medicare, or *per diem* rates and cost-per-case rates negotiated with various private insurers and government agencies. A small number of government hospitals are paid on a global budget basis. List prices now represent a small proportion of reimbursement. Relatively low payments by Medicare, Medicaid and managed care entities have led hospitals to "shift costs" to the traditional commercial insurers. This tactic is meeting with less and less success as these insurers exercise their own buyer-power and offer more managed care choices to consumers.

Patients: Consumers in the US value choice and have substantial freedom to choose among insurance packages, providers and treatment alternatives. Because certainty and comfort are also highly valued by the society, patients demand the very best medical care regardless of its cost, due to high levels of first-dollar coverage. The current regressive employer-based tax subsidized private health insurance system provides people with incentives to seek more insurance coverage and care than they might buy if they were paying more of the cost out of their own pockets.

Medicines: Today, providers and third-party payers actively select and purchase pharmaceutical products through a variety of means. Managed care insurers control prescribing through greater use of restrictive formularies, generic substitution and other drug utilization controls. As the buying power of managed care insurers, like the government, has increased, so has their commitment to becoming more cost-conscious. State Medicaid programs in the past have responded to increases in prescription prices by also using formularies, lowering their reimbursement levels to recipients and pharmacists, and encouraging generic substitution.

- Issues

The US health care system has a number of possible inequities and inefficiencies which include:

- access and equity problems reflected by the high percentage of the US population that is uninsured or under-insured;
- the propensity for others to over-insure[3] and potentially over-use medical services due, in large part, to the tax benefits associated with employer-based insurance;
- substantial excess capacity in the system, especially in the hospital sector;
- doubts about whether the level of resources devoted to technological development and diffusion is optimal;
- lack of "portability" of employer-based insurance coverage;
- risk selection problems in private health insurance markets; and
- some inefficiency of government intervention in health care markets.

- Reforms

Up until late 1992, a wide variety of reform proposals ranging from major restructuring to minor adjustments of the employment-based health insurance system had been introduced to increase access to health care and control costs. Recent health care reform initiatives confirm that a convergence is occurring centered around managed competition. Poll after poll confirms that the majority of Americans feel that the US health care system needs to be rebuilt or, at a minimum, requires fundamental change. National health care reform is most promising given the current unsustainable system.

- Political Environment

Prospects for meaningful reform this year will continue to be greatly challenged by:

[3] According to US Senator Durenburger, more than 100 million Americans are "over-insured" — people who have more financial protection than they need — i.e., anyone with first-dollar coverage.

- a lack of political consensus and support for "scorable"[4] reform measures;
- state and federal budget deficits;
- the unwillingness of the public to pay higher taxes without guarantees of cost containment, improved access and preservation of choice;
- a lack of consensus and support from highly influential health care groups (physicians, hospitals and insurers); and
- cultural preferences for pluralism, diversity, local solutions, and individual responsibility.[5]

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4 1990 legislation now requires that all bills enacted into law be budget-neutral. "Scoring" refers to how much the reform bill will cost (or save) the Federal Government and what impact the proposed legislation will have on national expenditures.

5 Enthoven and Kronick, 1989.

1.2 STRUCTURE OF THE HEALTH CARE SYSTEM

1.2.1 The Health Care System in Context

The health care system in the US has undergone significant changes over the last thirty years. During this time, health care financing expanded due to the growing economy and the passage of the Medicare and Medicaid public insurance programs in 1965. Following this expansionary period, a variety of piecemeal attempts to contain costs in both the public and private sectors emerged. More recently, reimbursements continue to change from retrospective, cost-based payments to prospective payments. This transition has put the US health care system in a state of disequilibrium with substantial expensive excess capacity, especially in the hospital sector.

Following World War II, the public sector implemented a variety of programs to expand both the supply of and demand for health care services. These included:[6]

- the Hill-Burton Act (1947) to provide government subsidies for the construction of hospitals;
- the GI Bill to enable many veterans to attain a medical education;
- the National Institutes of Health and health manpower legislation that encouraged training of physicians geared to specialty care and research;
- the Kerr-Mills Act (1960) that expanded financial assistance for health care to the poor; and
- the implementation of Medicare and Medicaid in 1966.

Perhaps no other piece of public policy has stimulated national health care spending and shaped the country's reimbursement system more than Medicare. The original Medicare program provided cost-based reimbursements for hospitals and fee-for-service reimbursements for physicians. Employment-based private health insurance, even though well-established when Medicare was introduced in 1966, generally only paid fixed amounts for hospital care and minimal coverage of physician services. Private insurers soon adopted both the broader coverage and the retrospective method of reimbursement used by Medicare, making private insurance benefits more comprehensive. Funding for the care of the nation's poor, including elderly poor, was also increased under the Medicaid program.

Under Medicare, hospitals were allowed to pass-through their costs of capital in their retrospective rates. These measures, combined with the Hill-Burton construction

[6] Davis, *et al.*, 1990.

subsidies, provided incentives for both the number of hospitals and the intensity of services to expand, laying the foundation for the excess capacity problems of today. Furthermore, legislation to subsidize medical school education contributed to a rapid growth in the number of physicians and the high ratio of specialties to general practitioners.[7]

Aaron (1991) points out that the rapid growth of the US health care system, which began in the 1960s, was supported by every major participant in the health care system — physicians, hospital administrators, businesses, insurance companies, suppliers, and the insured population — until the 1980s. During that period, the US economy had been growth-oriented and could afford high levels of health care expenditures by both the private and public sectors. More importantly, the retrospective cost-based reimbursement methods stimulated the development of new technologies and other medical research, producing sophisticated, high quality and widely available care for those with insurance.

In the mid-1970s, US economic growth began to slow and budgetary constraints at all levels of government began to mount. The Government shifted to implementing various measures aimed at containing health care costs. These enjoyed marginal success, at best. In 1971, the Federal Government began reducing its Medicaid contributions to the states, and mandated a five-month freeze on all hospital prices (later replaced with a seventeen-month, six percent inflation ceiling). Also, the federal Health Planning and Resource Development Act of 1974 required that all states receiving federal funds enact Certificate of Need (CON) programs. CON programs established state review and approval of planned capital investments and major health care expenditures.

At the same time, states began to experiment with innovative approaches to health care cost containment by establishing voluntary and mandatory rate-setting hospital reimbursement systems, encouraging alternative care facilities, such as ambulatory surgery centers and passing legislation which encouraged the formation of alternative delivery systems, such as HMOs. By 1974, twenty-two rate-setting systems were in existence and, by the end of 1985, rate-setting systems operated in thirty-five states.[8] These programs have shown limited success, however, and many have been dropped. Eakin (1991) found that state hospital rate regulation reduced costs modestly while CON programs probably increased costs. By 1986, CON requirements for states to receive federal health funds were dropped and many states have since discontinued these programs.

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[7] For example, general and family practice physicians increased 9.9 percent from 1983 to 1990, whereas medical specialists increased 23.1 percent during this period (AMA, 1992b).

[8] Davis, 1990.

As a result of rapid growth of Medicare hospital expenditures — from $5.3 billion (nominal) in 1970 to $36.7 billion (nominal) in 1982 — the Federal Government adopted a dramatically different payment method for hospitals in 1983.[9] This is known as the Prospective Payment System (PPS) based on DRGs. Hospitals are given a fixed payment for each patient with a particular diagnosis. If the hospital's costs are more than the fixed rate, the hospital absorbs the loss; if they are less, the hospital keeps the difference. The prospective payment system has changed hospital incentives. Since Medicare paid for 27.5 percent of all hospital care in 1983, hospitals had a strong incentive to reorganize and control costs.

The new system, coupled with similar moves by private insurers, has brought with it a decline in the average length of hospital stay and moved more traditional in-patient procedures to the less expensive out-patient setting. This has produced substantial excess hospital capacity. Since the 1980s, there has been an increase in hospital mergers and closures as average occupancy rates have fallen to the mid 60-percent range. The number of hospital beds declined 3.4 percent from 1980 to 1985 and eight percent from 1985 to 1990.[10] The number of hospital closures peaked in the late 1980s as total hospital margins[11] declined from 7.3 percent in 1984 to 4.2 percent in 1990.[12] Hospitals' PPS margins fell even more — from a high of 14.5 percent in 1984 to -3.6 percent in 1990.[13] Thus, while the Federal Government squeezes hospital profits through low administered reimbursements, profits are made up by charging higher prices to other payers, for example, patients covered by private insurance, or making money on non-in-patient operations, or by reducing costs.

Until the beginning of 1992, Medicare reimbursed physicians predominantly on a fee-for-service basis that rewarded them for providing more medical services. Medicare's physician expenditures rose dramatically due to this type of reimbursement system. In 1970, Medicare's physician expenditures were $1.6 billion (nominal) and increased to $24.2 billion (nominal) by 1988. Medicare recently replaced this payment system with a uniform national fee schedule that bases physician reimbursements on the resources used in each type of physician service, the Resource-Based Relative Value Scale (RBRVS) system. For the first time, volume performance standards were established to discourage physicians from offsetting the effects of any cuts in fees by increasing the number of patient visits. Physicians' delivery incentives will undoubtedly change as the new Medicare fixed fee schedule coupled with increased

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9 Unless otherwise noted, all US health care financing data was taken from the official government source — the US Health Care Financing Administration Office — compiled by Levit et al., 1991.

10 AMA, 1992b.

11 Total hospital margins compare hospital revenues and expenses for all in-patient and out-patient care as well as for non-patient care activities (PROPAC, 1992).

12 *Ibid.*

13 *Ibid.*

penetration of managed care replaces the traditional fee-for-service reimbursement system.

Private insurers have responded to escalating medical care costs by exercising their own buyer power and creating innovative alternative finance and delivery systems such as HMOs and experimenting with other forms of managed care. These include sophisticated utilization control programs and capitated payments to primary care physicians who act as "gatekeepers" for the patient's access to the rest of the system. Capitated risk-sharing contracts put physicians "at risk" for over-utilizing referrals to specialists and hospitals and, thus, create incentives to keep patients out of the hospital.[14] As premiums and health care costs paid by employers have escalated, employers have responded by offering lower wage increases, requiring greater contributions toward health care from employees in the form of higher premiums and cost-sharing, reducing benefits, and, for some, dropping coverage altogether. In addition, the prevalence of large, self-insured employers who negotiate directly with hospitals and physicians to obtain discounted prices for their patients has grown. The providers agree to give discounts in exchange for a flow of patients, and the patients (or the employers on their behalf) accept restrictions on provider choice in exchange for lower consumer out-of-pocket costs.

For patients, the US health care system is expensive to those without adequate insurance coverage, but provides high quality, sophisticated care that is quite accessible to those who have coverage. High quality care is not necessarily reflected in international health status indicators such as life expectancy or infant mortality rates, partly because of factors outside of health care. It is a system that provides a wide choice of providers and continues to allow patients to exercise a great deal of choice. However, many Americans are uninsured and continue to have limited access to the system. Competitive insurance markets have been very efficient in equating premiums with risks and in developing alternative delivery systems, but not without also aggravating inequities in the system as the number of uninsured or under-insured continues to grow.

One of the consequences of rising health care costs and cost containment pressures is that since the 1980s some 30 million US citizens have been without health insurance. In 1990, 33.4 million people, approximately 14 percent of the population, were uninsured while millions of others were under-insured. Furthermore, some private insurers try to avoid insuring high risk individuals who may make large insurance claims. This practice of "preferred risk selection" means that those with the greatest need for health insurance coverage must pay the highest premiums or go without coverage.

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14 "At risk" contracts with a physician base a portion of his compensation on the number and intensity of services referred out of the office, thereby giving the physician an incentive to provide the most cost-effective care through his own office.

In summary, the US health care system is the product of many forces. The early forces of the 1960s and 1970s were strongly expansionary as public and private funding grew to accommodate the demands of Americans for high quality health care. The subsequent failures of piecemeal cost containment efforts have led third-party payers in one of two directions. The Federal Government and many state governments have introduced prospective reimbursements but have also chosen simply to cut those reimbursements to providers based on sheer monopsony power. Private insurers have moved toward more utilization control and the adoption of other managed care techniques to restructure the incentives of patients and providers. The result for patients has been an increased awareness of health care costs. The result for providers has been lower profit margins and excess capacity for some, especially hospitals. It is a system in disequilibrium and transition, primed for reform. Structural reforms are needed if an efficient and equitable health care system is to evolve.

1.2.2 General Features of the Finance System

US national health care expenditures totalled $666.2 billion in 1990. The distribution of national health expenditures by payer has changed considerably over the past thirty years.[15] In 1960, consumer out-of-pocket payments represented almost half of all spending for health care, while private health insurance and other private funds, and spending by all levels of government each contributed approximately one-quarter. In 1990, private health insurance represented the largest share of spending at 33 percent, followed by consumer out-of-pocket payments at 20 percent, Medicare at 17 percent, other government programs at 14 percent, Medicaid at 11 percent, and other private funds at five percent (see Chart 1.1).

The US has a pluralistic, decentralized health care financing system. Employer-based private health insurance is the pervasive method of financing, covering more than 60 percent of the population. Although financed very differently, the US shares three characteristics with Japan, Germany and France:

- private physicians, public and private hospitals and patient choice,
- insurance provided through the workplace, and
- health insurance provided by multiple third-party insurers.[16]

The US, however, is the only major industrialized country that relies on out-of-pocket payments and private insurance for the majority of its health care spending. In 1990,

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15 In addition, there is a great deal of geographical variation in health care expenditure in the US which stems from a variation in the completeness of health insurance and secondarily, to variations in income and in medical practice (Frech, 1990). As one possible explanation, Phelps (1992) attributes these "variations" in medical practice to the problem of incomplete diffusion of medical information.

16 According to a 1991 US General Accounting Office (GAO) study.

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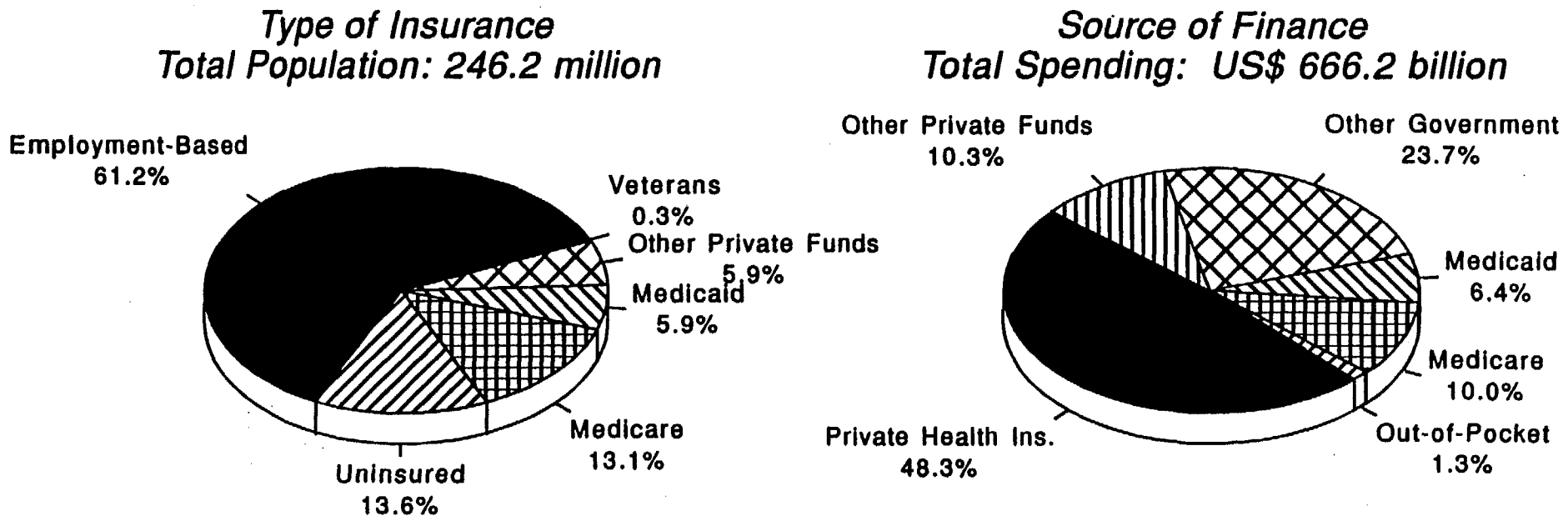
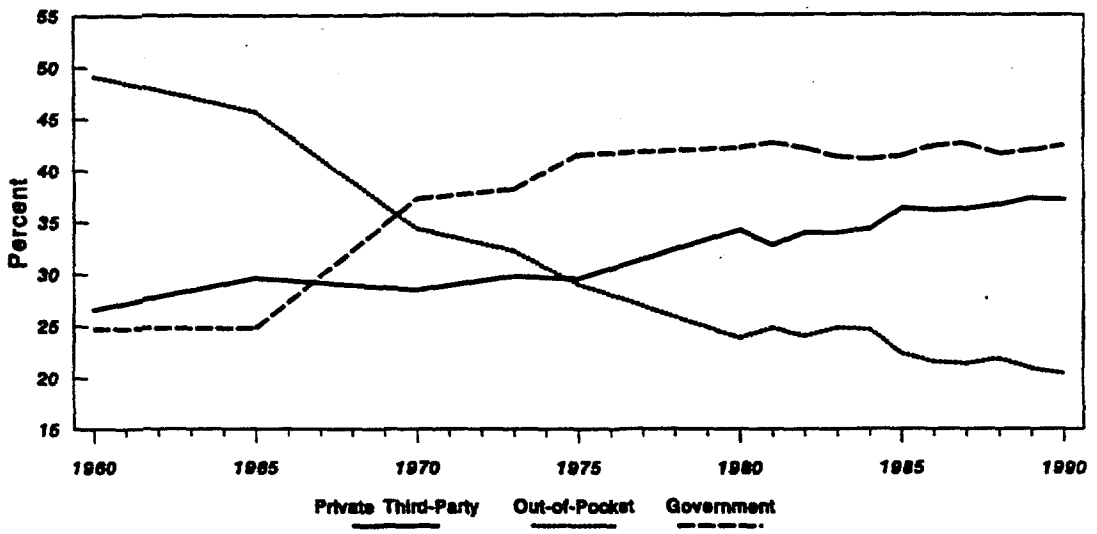
Chart 1.1
Health Insurance in the US in 1990



Source: US Health Care Financing Administration

these two sources together accounted for almost 54 percent of total personal health care expenditures (see Chart 1.2).

Chart 1.2
Sources of Financing of U.S. Health Expenditure
1960-1990*



* Selected years only.
Source: Health Care Financing Administration.

Insurers and governments are often involved in the pricing of health care services in the US. Most health care prices are set via competition in the private sector and administered pricing by government agencies in the public sector. Under the traditional fee-for-service reimbursement system, health care providers set the prices as a result of interaction between providers and consumers (and their insurers) in a competitive market. In a managed care insurance arrangement, buyers and sellers negotiate prices for health care services. The Federal Government's Medicare program has adopted administered prices based on usual and customary fees for hospital in-patient and some out-patient services (DRGs) and for physician services (RBRVS fee schedules). Furthermore, some states determine hospital rates by a regulatory formula in a manner similar to that used to determine rates for electricity provided by a public utility.

1.2.2.1 Private Insurance

Over the past three decades, the proportion of health care costs paid by private insurance has represented between 30 and 40 percent of all national health expenditures (see Chart 1.2).

Private insurance policies are regulated by the states and every state requires that insurance companies doing business in their state include certain benefits in their

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policies. The number of mandated health insurance benefits has dramatically increased over the last two decades.[17] These regulations have a large effect on the cost of private health insurance and make it "illegal" for an insurance company to offer a bare-bones, low-cost insurance policy to consumers who may only want to insure against catastrophic illnesses.[18] As a result, almost one-half of all large employers now self-insure their employees and, in doing so, are exempt from these state mandates and other Employee Retirement Income Security Act (ERISA) regulations (see Section 1.3.3).

The full amount of an employer's health insurance contribution can be excluded from both the employee's taxable income and from the employer's tax liability under state and federal laws. Individuals with higher incomes who choose very complete, costly health insurance coverage receive substantial subsidies and incentives to purchase excess (first-dollar) coverage through the tax system. Danzon (1992c) suggests that current untaxed health benefits in the US provide a $60 billion tax subsidy for middle and upper-income people. On the other hand, low-income people get much lower tax subsidies or none at all if their employer does not offer health insurance as an employee benefit. This system is clearly regressive.[19]

Faced with budget deficits at the federal and state levels, public spending has not been able to keep up with the health care needs of the rising numbers of elderly and poor. As a result, the public sector provides relatively fewer medical services and the private sector is left paying higher costs for the medical needs of all — insured and uninsured alike.

The rapid increase in the cost of health care has raised the level of premiums for private health insurance paid primarily by employers who, on average, pay about 90 percent of the private health insurance premium for single workers and 75 percent of the cost of family coverage.[20] Between 1977 and 1987, the average real premium paid by employers rose from $1,111 to $1,656 (in 1987 dollars), or 49 percent.[21] In contrast, real median family income in the US grew by only eight percent during this same time period.[22]

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17 In 1970, there were only 30 mandated health insurance benefits (*Health Benefits Letter*, 1992). As of July 31, 1992, 1,081 state-mandated benefits had been identified (*Ibid.*). Required benefits vary from state to state but can include services provided by chiropractors, dentists, podiatrists, optometrists, alcoholism treatment, mammography screening and maternity care (*Ibid.*) — regardless of the consumer's willingness to pay for such coverage (*Economic Report of the President*, 1991).

18 *Ibid.*

19 Wagstaff, *et al.*, 1989.

20 *Economic Report of the President*, 1991.

21 US CBO, 1991.

22 A. Silverman, US Department of Commerce.

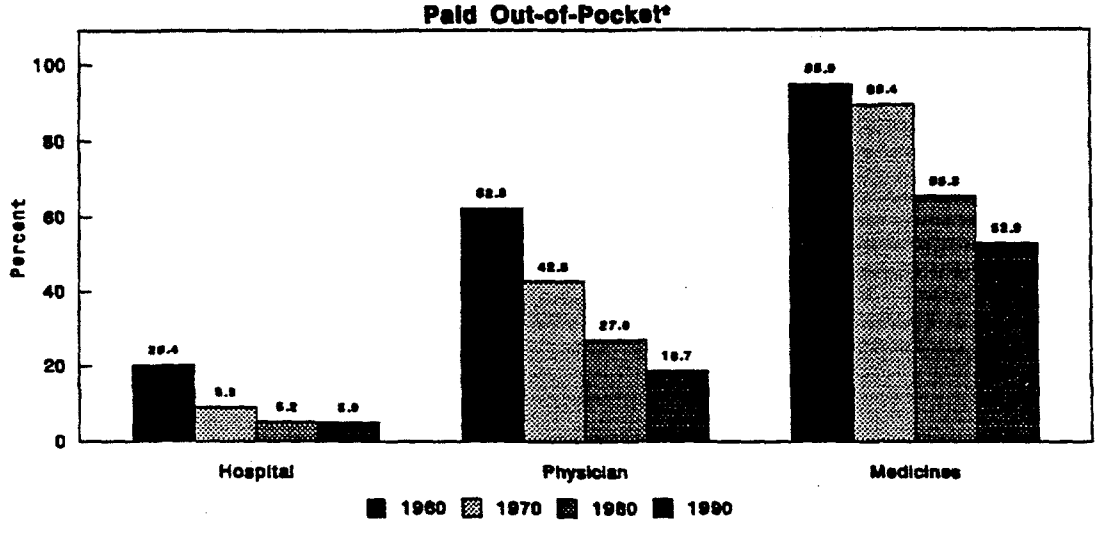
1.2.2.2 *Consumer Out-of-Pocket*

The second largest source of health care expenditures in 1990 was consumer out-of-pocket expenditure. Over time, out-of-pocket costs paid by consumers have fallen sharply (see Chart 1.2). In 1965, consumers paid 46 percent of all health care services directly out-of-pocket. By 1990, out-of-pocket payments covered only 20 percent of all expenses. This has helped contribute to a rise in the quantity of medical care services demanded and purchased over the last three decades. Still, out-of-pocket expenditures represent a larger share of total health care costs than in most other countries. For example, out-of-pocket costs are only seven percent in West Germany and three percent in the United Kingdom.[23]

The share of expenses consumers pay out-of-pocket varies considerably among health care services (see Chart 1.3). In 1990, consumers paid five percent of all hospital costs out-of-pocket, 19 percent of all physician costs and 53 percent of all medicines.[24]

Chart 1.3

Share of U.S. Health Care Expenses Paid Out-of-Pocket*



* Selected years
Source: Health Care Financing Administration.

1.2.2.3 *Medicare*

Medicare accounted for 17 percent of national health care expenditures in 1990, while providing coverage for 13 percent of the US population who include those 65 years of age and over, the disabled, and those with end-stage renal disease. As the US

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23 US CBO, 1991.

24 *Economic Report of the President*, 1993.

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population has aged, Medicare enrollees have increased from 19.5 million (or 9.7 percent of the US resident population) in 1967 to 34.2 million (or 13 percent of the population) in 1990 — a 75 percent increase. Health care spending is especially high in the last year of life. In 1979, the five percent of aged beneficiaries who were in their last year of life accounted for 29 percent of all Medicare expenditures.[25] Total public Medicare expenditures were $108.9 billion in 1990, up from $3.4 billion (nominal) in 1967. The average annual rate of growth in Medicare expenditures over this period was almost 15 percent.

Medicare is funded through a combination of taxes on wages, premiums and direct payments by beneficiaries. The program provides two basic forms of coverage: Part A covers in-patient institutional services[26] and Part B provides supplemental medical insurance for physician services and other out-patient services, supplies, and equipment. Parts A and B represented 61 percent and 39 percent of total Medicare spending in 1990, respectively. For 1992, in-patient coverage provided under Part A had a $652 deductible for every "spell of illness"[27] with no copayments for the first 60 days and a coinsurance rate of $163 per day for the 61st to the 90th days of hospitalization.[28] Coverage provided under Part B for physician services is voluntary and required a premium of $381.60 per year in 1992, a $100 per year deductible and a 20 percent coinsurance requirement for any out-patient services purchased.[29] Currently, there is no Medicare coverage of out-patient prescription medicines or for long-term care — expenses that account for a significant portion of the health care needs of the elderly and the disabled.[30] Because financial risk under Medicare is open-ended (without limit) and has significant coinsurance gaps, about 79 percent of Medicare enrollees have private supplemental first-dollar insurance protection which pays the deductibles and coinsurance rates.[31] In 1990, supplemental insurance included Medigap policies purchased by 31 percent of Medicare beneficiaries, 30 percent of employment-based group retiree health plans and benefits provided under

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25 *Op. cit.*, p. 152.

26 In-patient hospital services, skilled nursing facility services, home health services, and hospice services are included (AMA, 1992a).

27 A spell of illness is a period of time that begins with the first day a Medicare enrollee is furnished in-patient services in a hospital or nursing home and ends when the patient has been out of the facility for 60 consecutive days. A person may have several "spells" and, thus, pay several deductibles per year (*Ibid.*).

28 AMA, 1992a.

29 *Ibid.*

30 The Clinton Administration favors inclusion of both of these benefits in the basic benefit package. Funding considerations will ultimately decide if this is feasible, and if so, over what phased-in time period.

31 PROPAC, 1992.

Medicaid received by another 18 percent.[32] Some studies show that Medigap insurance policies boost Medicare costs by reducing beneficiaries' out-of-pocket payments and increasing use of Medicare services.

1.2.2.4 Other Government Programs

Other government program expenditures made up 14 percent of total national health care spending in 1990. State governments are increasingly facing the same budgetary pressures being experienced by the Federal Government.[33] Health expenditures made by the Federal Government outside of the Medicare and Medicaid programs include: the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Veterans Administration (VA), Federal Employees Health Benefits Program (FEHBP) and Indian Health Services. The remainder of federal funds (less than one-fifth) is spent on public health activities, research and construction, and administrative expenses of public programs.

1.2.2.5 Medicaid

Federal and state expenditures under the Medicaid program accounted for 11 percent of total national health care spending in 1990. Medicaid provides about one-half of the revenue used to fund the nation's nursing home industry. State Medicaid expenses represent the fastest growing items in state budgets in most large states. Some 25.5 million Americans, approximately ten percent of the US population, received Medicaid services in 1990.

Medicaid is financed primarily from federal and state general revenues. As these funds have tightened, eligibility has been scaled back and the states have been forced to bear an increasingly larger share of Medicaid's spiralling costs. When Medicaid was introduced in 1966, three out of every four poor Americans were eligible for coverage. Today, only 38 percent of the total population living below the poverty line is covered by Medicaid.[34] Nevertheless, the number of Medicaid recipients has increased from about ten million in 1967 to 25.5 million in 1990, an increase of 155 percent. However, because of low reimbursement fees established by the states, Medicaid patients often have trouble finding a physician who will treat them.[35]

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32 *Ibid.*

33 For instance, public health programs in the state of California will face $470 million in budget cuts with the passage of the latest budget. Included in the cuts are $200 million in reductions in the state's spending on Medicaid hospital fees, a $28 million cut in nursing home payments, a new 10-prescription-a-month limit on prescription medicine coverage, and a 9.5 percent cut in payments to surgeons, radiologists and anesthesiologists (*Medicine & Health*, September 7, 1992).

34 Hopkins, 1992.

35 For example, Medicaid currently pays only $7 to $25 for a routine doctor's office visit in New York (Colburn, 1992).

1.2.2.6 Other Private Funds

Lastly, funds from various private sources such as hospital non-patient revenues and philanthropy contributed four percent of total national health care expenditures in 1990.

1.2.3 General Features of the Delivery System

Health care services are provided in a loosely structured delivery system organized at the local level.

- Hospitals

  There are about 6,700 hospitals in the United States, including 5,480 community, acute care hospitals,[36] 880 specialty hospitals (e.g. psychiatric, rehabilitation, long-term care), and 340 Federal hospitals open only to military personnel, veterans, or native Americans. Of the 5,480 community hospitals, non-profit hospitals represent 59 percent, local government hospitals 27 percent, and for-profit hospitals 14 percent. There are 3.9 community hospital beds for each 1,000 residents, although this varies around the country. There were 33 million hospital admissions in 1990 with an average length of stay per admission of 9.2 days. Hospital stays are shorter and admission rates are lower in the United States compared with other OECD countries.[37] The average hospital occupancy rate, 66 percent, is lower in the United States than in other OECD countries, however, this rate varies and may be 40 percent or lower in some areas, especially rural areas.[38]

  The largest component of total national health care expenditures continues to be hospital expenditures. In 1990, hospital expenditures accounted for 38 percent ($256 billion) of these expenditures. Profit margins for hospitals have dropped as occupancy rates have fallen, the number of staffed beds decreased and more and more surgeries have moved into an out-patient setting. As mentioned above, these changes are a consequence of the Federal Government's new prospective payment system introduced in 1983, and the cost containment efforts of private insurers and states experimenting with alternative financing methods for their Medicaid programs over the last two decades. In addition. several states have turned to contracting with hospitals who have discounted

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36 Community hospitals, which comprised 86 percent of all hospitals in 1990, include all short-term, general, non-federal and other special hospitals whose facilities are open to the public. As more and more community hospitals face lower occupancy rates, the number of community hospitals continues to decline as the number of specialty hospitals increases.

37 A recent study found that the US had "proportionally fewer hospital beds than Canada (3.9 vs. 5.4 per 1000 population), fewer admissions (129 vs. 142 per 1000 population), and shorter mean stays (7.2 vs. 11.2 days)", (Redelmeier and Fuchs, 1993).

38 This paragraph was taken from De Lew, *et al.*, 1992, p. 155 (footnotes added by NERA).

their fees. Price competition among providers in arrangements such as these can be more successful in containing costs than administered pricing policies. Today, insurers, business, and governments negotiate steeply discounted prices with heavily competing hospitals, especially in certain metropolitan markets.

- Physicians

In 1990, there were 547,310 active physicians in the US, 244 physicians per 100,000 population.[39] The 1990 physician population is composed of 70,480 general/family practitioners and 476,830 specialists, almost seven specialists for every general practitioner.[40]

Expenditures for physician services constituted 19 percent ($125.7 billion) of total national health care spending in 1990. Under traditional fee-for-service and cost-based reimbursement arrangements, physicians had strong incentives to deliver high quality care but few incentives to control costs. The financial incentives for physicians have since changed with the introduction of prospective fee schedules for physicians by Medicare in 1992 and with the increasing penetration of managed care systems with capitation and other risk sharing arrangements. In 1992, 27 percent of all physician revenue came from Medicare reimbursements.[41] Consequently, physicians, hospitals and other medical care providers have now lost much of their traditional autonomous control over fee schedules to insurers. Responding to cost containment pressures from both private and public insurers, physicians and hospitals are beginning to get together to offer employers vertically integrated packages of medical services. Hospital mergers, preferred provider organizations and joint ventures are just a few examples.[42]

Traditional health care delivery systems are being replaced with alternative systems which now offer financial incentives for providers. A small number of

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39 AMA, 1992b.

40 *Ibid.*

41 Of those physicians with HMO and/or Independent Practice Association (IPA) contracts, 22 percent of all physician revenue came from such contracts (AMA, 1992c).

42 These combinations among health care providers generally enhance efficiency. However, there is some concern that such combinations may result in a conspiracy among providers or monopoly. Vigorous antitrust enforcement in health care must exist in any system that relies on market-oriented solutions. "[A]ntitrust enforcement has played an important role in facilitating reforms in the health care sector and the hospital industry, in particular, by removing obstacles to the use of innovations such as managed care to take advantage of competition to contain costs and overcome some of the inefficiencies of health care markets", (Egan, 1992).

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insurers have even entered the health care delivery market adding to the competition amongst providers.[43]

- Medicines

Pharmaceuticals and other non-durable medical goods accounted for nine percent (or $54.6 billion) of total national health care expenditures in 1990. Retail sales of prescription medicines amounted to $32.3 billion in 1990, five percent of total national health care expenditures. Approximately 80 percent of prescription medicines are sold through pharmacies. Consumer out-of-pocket spending accounts for almost one-half of all prescription medicine purchases. Private health insurance covered 26 percent of all prescription drug purchases while public programs, mostly Medicaid, covered the remaining 19 percent. Managed care entities, consolidated networks of physicians and hospitals, and all levels of government now demand and receive price concessions on medicines.

The US pharmaceutical industry consists of approximately 790 firms, about 100 of which are research oriented. Almost half of the 97 new drugs marketed worldwide between 1975 and 1989 originated in the US, more than three times the number from any other country. In order to enhance their capacity to compete across several product lines both domestically and abroad, many pharmaceutical companies have merged and entered into joint ventures since the late 1980s.[44]

- Long-Term Care

In 1990, there were 9,008 nursing homes in the US, 29 percent of these facilities were classified as not-for-profit facilities.

Expenditures for the nursing homes in the US constituted eight percent ($53.1 billion) of total national health care expenditures in 1990. The introduction of Medicare's prospective payment system has increased the number of patients sent to nursing homes and increased the severity-of-illness levels there because hospitals now have strong financial incentives to discharge Medicare patients early. There is very little private insurance coverage for long-term care in the US. Consumers directly pay for the majority of the cost of nursing home care themselves, accounting for 45 percent of all nursing home care costs in 1990.

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43 Some insurers use the staff model HMO to become vertically integrated. The insurer may buy a hospital, hire physicians or contract with a "foundation" of salaried physicians to provide virtually the whole range of medical services. There are some HMOs which have their own hospitals while others "rent" empty beds in local hospitals (see subsection 1.3.3).

44 Pollard, 1990.

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Medicaid paid 45 percent of the costs as well, Medicare paid five percent and private insurance paid for only one percent.

Long-term care health insurance was not offered under employer-sponsored policies until 1987.[45] Purchase of this type of insurance is strictly voluntary with roughly ten percent of all employees choosing to purchase long-term care coverage either for themselves, their immediate family, or their parents/parents-in-law.[46] Since long-term care premiums increase substantially with age, only 10 to 50 percent of all current or future elderly will ever be able to afford private long-term care coverage if reforms are not made.[47]

As some states have faced increased shortages of Medicaid funds, Medicaid nursing home eligibility requirements have been made more stringent and reimbursement levels have been lowered. Nursing homes have strong incentives to admit the more lucrative, private-paying patient regardless of need and the less ill Medicaid patient, creating an access problem for those Medicaid patients who are seriously ill.

- Dentists

In 1989, there were 148,300 active dentists in the US.[48] Expenditures for dental services constituted five percent ($34 billion) of total national health care spending in 1990.[49] Even though more employers today offer some level of dental coverage, patient coinsurance rates have been on the rise. Employers and private insurers offering dental coverage are increasingly turning to managed care arrangements like the preferred provider organization to obtain discounted fees in exchange for larger volumes of patients.

- Other

Expenditures for home care services constituted one percent ($6.9 billion) and expenditures for vision care and all other medical goods constituted eight percent ($55 billion) of total national health care spending in 1990.

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45 Scanlon, 1992.

46 *Ibid.*

47 *Ibid.* For instance, a 50-year old long-term care policy purchaser will typically pay a premium of $483 (without inflation protection) for a four year, $80 per day nursing home care policy with a 20-day deductible. The same policy would cost a 65-year old $1,135 and a 79-year old $3,841 (*Ibid.*).

48 AMA, 1992b.

49 In 1990, the largest portion of dental services (53 percent) was paid out of the consumer's own pocket while private insurance funds paid for 44 percent of the total.

1.2.4 Inputs and Outputs of the System

The US spent over $666 billion on national health care in 1990 — or 12.2 percent of GNP. In comparison, health care expenditures constituted a little over nine percent of GNP in 1980, a little more than seven percent in 1970 and five percent in 1960. In the US, national expenditure consists of personal health care expenditures plus spending on research, construction, administration, and public health activities. Not only are national health care expenditures higher than those in any other country, they are continuing to rise faster than the GNP. The US is not alone. Countries such as Germany, the UK and Canada have all experienced large increases in health care spending between 1960 and 1990. The most significant difference in US health care expenditures compared to those in other industrialized countries appears to be derived from the high prices of medical care services in the US. Since 1980, US health care input prices have risen 2.5 percent per annum faster, on average, than inflation, while the comparable figure for European health care prices is around 0.5 percent *per annum*.[50] In addition, Poullier says that health care sector workers in the US earn more relative to the average wage. For instance, US physicians earn around 5 to 5.5 times the average US wage.

As in most industrialized countries, life expectancy rates continue to rise in the US for both men and women, but they still lag behind those in Japan, Canada, Italy and other countries.[51] Infant mortality rates continue to decline in the US but are still amongst the highest of most industrialized countries.[52]

International health status indicators are imperfect measures of the quality of health care. Some of the US life expectancy data may be driven by more urban violence than in other countries under study. Many observers believe that improved life expectancy and infant mortality health status indicators in the US are mainly applicable to the middle class, not the poor. Poor people often lack health insurance, which may cause them to wait until a problem is severe before seeking medical attention. Even those in the public Medicaid program have difficulty in receiving care.[53] As a result, poor people go to the hospital more often and stay longer. In various studies that examined the health outcomes of the poor in hospitals, the poor spent more than twice as many

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50 NERA interview with Dr. Jean Pierre Poullier on November 6, 1992.

51 For instance, in 1990 the US life expectancy rate for males was 72.1 years and 79 years for females (OECD, 1991). In Japan, the 1989 rate was 75.9 years for males and 81.8 years for females and in the United Kingdom it was 72.8 years for males and 78 years for females (*Ibid.*).

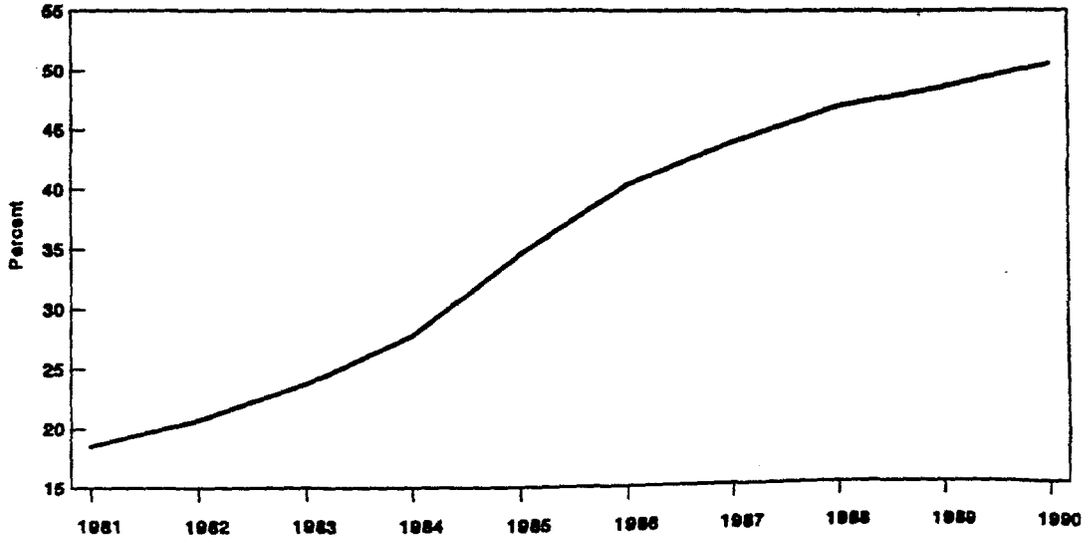
52 The US infant mortality rate was 9.2 per 1,000 live births in 1990, well above the French rate of 7.2, the British rate of 7.9, and the 1989 Japanese rate of 4.6 per 1,000 live births (*Ibid.*).

53 Nationally, one out of four physicians will not accept any Medicaid patients at all, and two out of three physicians will only see Medicaid patients on a limited basis (Colburn, 1992).

days hospitalized as other more affluent groups and had death rates 44 percent to 124 percent higher than privately-insured patients.[54]

These health status indicators do not necessarily reflect the successful lower utilization rates of health care services found in the US compared to other countries. Americans make fewer physician visits *per capita* than, for example, the Japanese, Germans and Canadians.[55] In 1990, a little over one half of all surgeries in the US were performed in an out-patient setting, a growing trend over the last nine years (see Chart 1.4).[56] For those patients who are hospitalized, the 1989 average length of stay in the US was 7.2 days compared to 51.4 days in Japan, 16.2 days in Germany and 13.0 days in Canada.[57]

Chart 1.4
U.S. Outpatient Surgeries as a Percentage of Total Surgeries Performed 1981-90



Source: AHA Selected Hospital Statistics, 1981-1990.

Access to highly specialized medical care with state-of-the-art medical technology is relatively easy with the appropriate insurance coverage or one's own private funds. The US is also the world leader in developing many new medical technologies and treatments. The diffusion of technologies allows for the benefits of medical research to become more quickly and readily available to most of the insured population.

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54 *Ibid.*

55 OECD, 1991.

56 AHA, 1992b.

57 OECD, 1991.

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However, there is some concern that diffusion of technology can be hindered in a number of ways: the regulatory process required for marketing approval[58] and the increased use of drug formularies by managed-care insurers and hospitals.

The increase in empty hospital beds, falling occupancy rates and the move toward out-patient surgery have left hospitals to compete for physicians and patients, in part, through the proliferation of medical technology. The excess capacity problem is magnified by the federal government determining prices for Medicare reimbursements — and not getting it right. For example, a recent US GAO report found that current Medicare reimbursement rates are too high for MRI exams and only support needless MRI proliferation in some areas by reimbursing providers for excess capacity.[59]

[58] Legislation was passed in 1992 that imposes user fees on firms seeking approvals of new pharmaceuticals. Fees will allow the FDA to hire more staff to review applications and hopefully speed up the drug approval process.

[59] US GAO, 1992.

1.3 ANALYSIS OF INDIVIDUAL SECTORS

1.3.1 Key Participants in the Health Care System

The key participants in the US health care system with the largest stakes (see Chart 1.5) are:

- the patients;
- the payers
  - the public (government) payers
  - the private insurers
    - traditional
    - managed care
- physicians;
- hospitals;
- the pharmaceutical industry; and
- others (nursing homes, home health care, etc.).

Of course, there are a number of other participants with stakes in the health care system such as free-standing ambulatory surgical centers (ASCs) and manufacturers of medical devices. However, we will focus only on the above list of key participants in this section.

1.3.2 Patients

Dissatisfaction with the US health care system has been on the rise since the late 1980s and appears to be driven by very specific issues. These include unprecedented increases in health care costs and the fear of losing all or part of one's employment-based health insurance benefits.[60] In several comparative international surveys conducted with residents of the US, Canada, Great Britain and (West) Germany, Americans reported very low levels of support for their current health care system. While 89 percent of Americans surveyed in 1990 desired fundamental change in the current US health care system, 93 percent considered the care they received from doctors and hospitals to be of good quality.[61]

Blendon and others have studied the satisfaction levels of citizens of different countries and found that Americans are the least satisfied with their current health care system. In a ten nation survey[62] conducted in 1990, 60 percent of the Americans surveyed said that the US health care system needed fundamental changes and 29 percent said that

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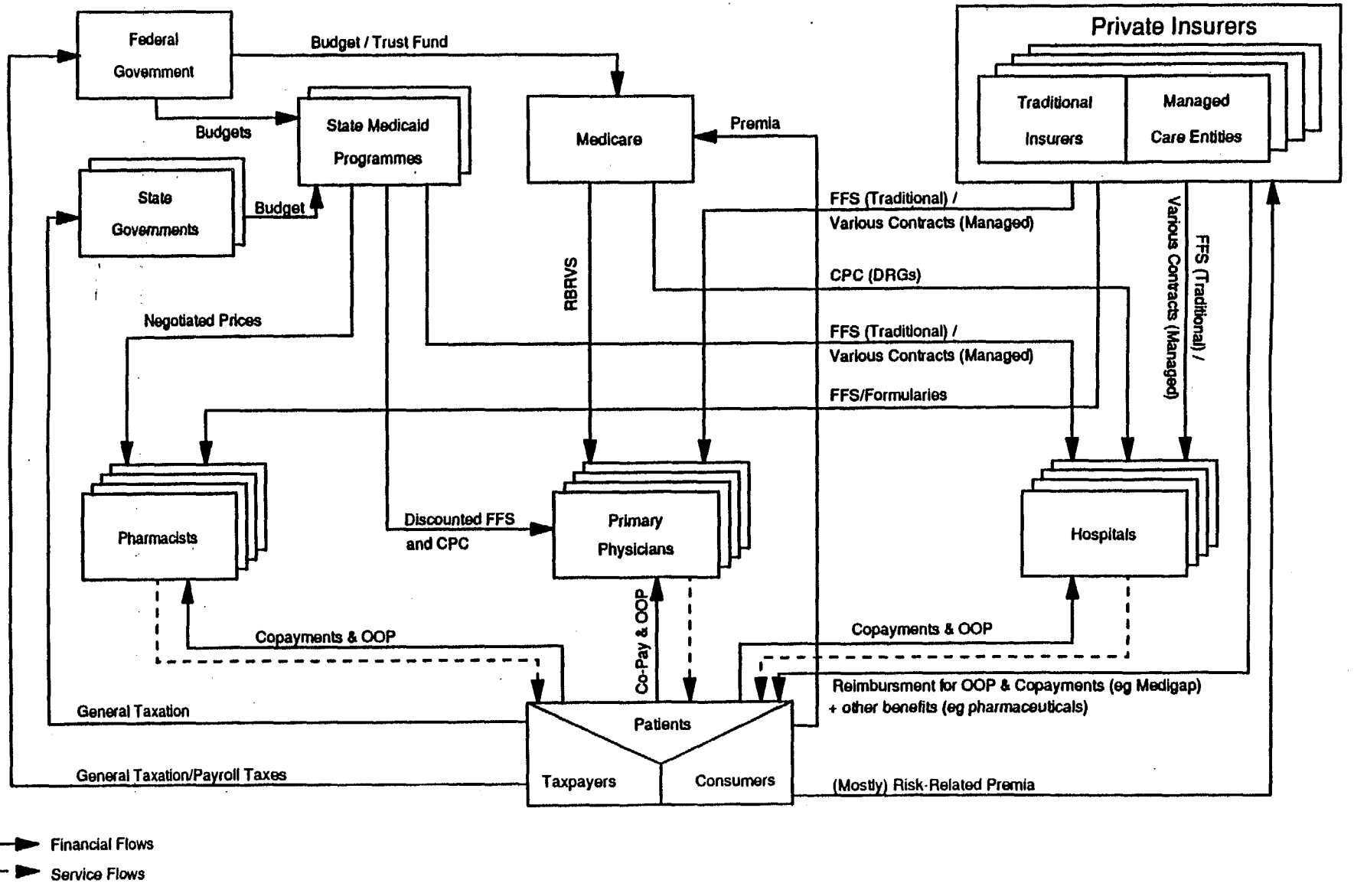
[60] Blendon and Donelan, 1991.

[61] Blendon, *et al.*, 1990.

[62] The survey included Canada, the Netherlands, West Germany, France, Australia, Sweden, Japan, the United Kingdom, Italy and the US.

Chart 1.5
Key Participants in the Health Care System in the United States



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the health care system needed a complete rebuilding.[63] Blendon, *et al.* (1990) conclude that major dissatisfaction with the American health care system lies in inadequate financial protection provided by the current health insurance system and the concern with high out-of-pocket costs. Subsequently, they believe that these two features taken together lead 89 percent of Americans surveyed to report they desired a fundamental change in the current health care system.[64] Today, politicians are responding to this apparent dissatisfaction by introducing health care reform measures at the national and state government level in the US.

1.3.2.1 The Uninsured

Patients want good access to high quality, technologically sophisticated health care without an inordinate amount of financial risk — but only those with insurance are likely to receive such access. In 1990, 86.4 percent of Americans (212.8 million) were protected by some form of public or private health insurance, but 14 percent (33.4 million) were still without any form of coverage. The number of uninsured has been above 30 million since 1980 and has been growing slowly since. The US Congressional Budget Office (US CBO) estimates that the proportion of uninsured is currently 30 percent higher than it was in the late seventies.[65] Many of these uninsured are poor, but they still do not qualify for public assistance under Medicaid. People 65 years of age and over are the least likely to be without any health insurance coverage since all of them are eligible for coverage under Medicare. Equally important, many of the insured are substantially under-insured and face tremendous financial risk if they require long-term or catastrophic care.

Young adults aged 18 to 24 are the group most likely to lack insurance; slightly more than 25 percent of this age group was without insurance in 1990.[66] The lack of insurance is not simply due to unemployment. Approximately 81 percent of the uninsured population has some connection to the work force as an employee or dependent of an employed worker.[67] Slightly more than half of uninsured workers are in firms with fewer than twenty-five employees.[68] The costs of coverage are typically higher for small firms than for larger ones due to higher premium costs and

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[63] Blendon and Donelan, 1991.

[64] Blendon, *et al.*, 1990.

[65] US CBO, 1991.

[66] *Ibid.* This group, however, represents the relatively healthy segment of the population. They may choose to bear the risk of covering health problems themselves if they are risk neutral or risk loving. A risk neutral individual will not purchase loaded insurance (i.e., one that includes an overhead for insurers). Risk aversion is a necessary condition for the purchase of loaded insurance.

[67] *Ibid.*

[68] *Ibid.*

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less favorable tax treatment.[69] In addition, small firms face a higher incidence of preferred risk selection.

Those people without insurance in the US face a barrier to adequate health care. This group tends to be poorer since insurance coverage strongly depends on income, which usually comes from employment.[70] The uninsured are also much less likely to receive state-of-the-art medical care.[71] Once hospitalized, uninsured patients are more likely to die than privately insured patients. There is growing evidence that uninsured persons have difficulty gaining access to the health care system, and, if and when they do, it is sometimes too late or often more costly to treat their health problem. Many poor people use hospital emergency rooms for preventive and other forms of primary care. This is an inefficient use of costly medical resources. Taxpayers and insurers indirectly pay these costs through cost-shifting mechanisms used by hospitals to cover all costs. Both Medicare and Medicaid payments to hospitals are substantially below costs while payments from private insurers are higher than costs to cover the shortfall created by the public insurers. "For proprietary hospitals, which have the highest average charge markup, private insurers' payments exceed costs by an average of 41 percent."[72] Between 1980 and 1988, the amount of real uncompensated care provided by all hospitals in the US doubled from $5 billion to $9 billion (in 1987 dollars).[73]

1.3.2.2 The Insured

The current US tax system provides built-in incentives for patients to secure a lot of insurance. Current tax subsidies to employer-based health insurance contributions lead to the purchase of first-dollar coverage insurance, which can lead to low-benefit, high-cost care being demanded and provided. Evidence from various studies suggests that the amount of health care demanded would decline if consumers paid more out-of-pocket for health care. A US CBO study (1991) cites evidence that if the average coinsurance rate in 1989 had been increased from 21 percent to 31 percent, a decrease in health care spending between one and two percent — or about $6 to $12 billion — would have occurred.

Employer-based health insurance is not portable; therefore, employees with existing health problems (their own or dependents) have incentives to not change jobs for fear

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69 While corporations can deduct 100 percent of health insurance premium costs as a business expense for all employees, the self-employed lost their 25 percent deduction last year when the law mandating the smaller deduction expired and was not extended.

70 While 96 percent of all Americans in families making more than $50,000 a year have private health insurance, only 35 percent of those in families making less than $14,000 per year have private health insurance (Colburn, 1992).

71 *Ibid.*

72 PROPAC, 1992.

73 Blendon and Edwards, 1991.

of losing existing benefits that may not be offered elsewhere. Consequently, there is some lack of labor mobility.

Americans with health insurance now pay a higher proportion of their health insurance premiums[74] and are often responsible for higher copayments under their current health care plan. Some have fewer covered benefits, as well. Patients, faced with financial incentives, are now encouraged to shop more than ever before. Insurers and providers are competing by innovating and thereby providing consumers choices of alternative health care delivery systems such as HMOs, which consumers have become more willing to choose. HMO membership has quintupled in the past fifteen years, from six million people in 1976 to nearly 30 million in 1990.[75] However, in exchange for lower premiums, people are willing to accept some restrictions on choice of a primary care physician, specialists and hospitals. When seeking specialized care, many HMO subscribers may still prefer to "opt-out" of the traditional restrictive HMO system and pay a higher coinsurance rate for having open choice of specialist physicians. These strong consumer preferences have led to a substantial enrolment increase in "open-ended" HMOs.[76] Open-ended HMOs provide the safety valve of choice required in an efficient competitive insurance and delivery market.

With the proliferation of alternative delivery systems, Americans have even more choices within private insurance available to them now. In addition, consumers are becoming more sophisticated buyers of health care. For instance, there is evidence that a few consumers are starting to use the US Health Care Financing Administration's (HCFA's) mortality data in deciding where to get hospital treatment.[77] Medical outcomes data has begun providing a few consumers and payers with a useful tool in choosing treatment alternatives.[78] As further evidence of the greater sophistication of consumers, pharmaceutical firms are now advertising a small number of prescription medicines directly to consumers. For informed consumers with insurance, access to sophisticated, high quality care is widespread, producing signals for allocative efficiency.

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74 In 1983, 67 percent of employers surveyed paid the total cost of health premiums for their employees. In 1990, only 51 percent of those surveyed paid the total cost (Blendon and Donelan, 1991).

75 InterStudy, 1991 and 1992.

76 In an open-ended HMO, enrollees have the choice to stay fully covered within the HMO network of providers or to receive care from a non-HMO physician, which will usually require that they pay some combination of deductible, copayment, or coinsurance (InterStudy, 1991 and 1992).

77 Petitte, 1992.

78 *Ibid.*

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1.3.3 Payers

Health care in the US is financed by a mix of both private and public sources. Employment-based private health insurance is the predominant form of insurance, covering 151 million people (or 61 percent of the US population) in 1990. The federal government's Medicare program financed the health care for 32.2 million elderly people (13 percent). The federal and state run Medicaid programs financed care for 14.6 million poor Americans (six percent). The remainder of health care financing in 1990 came from consumers' private funds (six percent) and various other state and federal government programs. Providers and insurers also indirectly paid a large share of the health care costs of the 33.4 million uninsured Americans (14 percent - see Chart 1.2).[79]

1.3.3.1 Private Insurers

1.3.3.1.1 Traditional

Traditional private health insurance plans are complex in structure and vary greatly in the types of benefits offered and various cost-sharing requirements. Individuals with private insurance face different prices for medical care, quite often at zero price which can lead to excessive health care consumption by the patient and inefficient provision of services by the provider. There is increasing use of copayments and coinsurance to make consumers more sensitive to prices of medical services. These plans often have a stop-loss provision that caps a patients' out-of-pocket payments over a specific period.

Private health insurance policies with commercial insurers can contain any combination of the following major types of health insurance:

- Major medical insurance provides broad and substantial protection for large, unpredictable medical expenses. Insurance of this type is offered in one of two ways: comprehensive basic and extended coverage or supplemental basic hospital-physician-surgeon expense insurance. Most major medical policies require some form of deductible and coinsurance payments by the insured person.

- Hospital/Medical insurance provides specific benefits for hospital services, supplies and room and board during hospital confinement.

- Prescription drug coverage reimburses for the costs of medicines prescribed by physicians. Although 75 percent of those under age 65 have some type of

[79] Some providers charge rates that incorporate a portion of their cost for uncompensated care. For example, hospitals in Maryland are allowed to include an adjustment in rates for indigent care.

prescription drug coverage, only 31 percent of their expenses for medicines are paid for by private insurers.[80]

- Disability income protection (loss of income) insurance replaces part of an employee's income lost as a result of an accident, illness or pregnancy. Policies are generally divided into those that provide benefits for up to two years (short-term) and those that provide benefits for longer periods of time (long-term). Depending upon the policy, long-term disability insurance usually provides benefits for at least five years, to the age of 65, or for a lifetime. When disability coverage is provided through the employer, benefits are usually integrated with public programs such as Social Security so that total benefits from these sources generally do not exceed 60 percent of the employee's earnings.

- Dental expense insurance reimburses for the costs associated with dental services and supplies and encourages preventive care. Dental plans normally require substantial patient copayments, excluding expenses for preventive care such as cleaning and x-rays.

- Long-term care insurance provides broad-ranged maintenance and health services to the chronically ill, disabled, or mentally retarded on either an in-patient or out-patient basis or entirely at home. By the end of 1990, more than 1.9 million people had purchased long-term insurance, less than one percent of the total population.[81] This is a very small percentage of the US population and presents a major risk for the rapidly rising number of elderly and a significant risk for people of all ages.

The scope of health insurance coverage differs from industry to industry. Coverage is less likely to be offered by firms employing large proportions of low-wage workers, part-time workers, or those that experience high employee turnover. In addition, specifics of health insurance coverage differ from one geographical market to the next.

Commercial insurers have moved away from basing premiums upon community-rating,[82] and have switched to using experience-rating. Experience-rating bases the premium for a given group on the average expected costs of insuring that group alone, while community ratings are based upon the expected costs per person of providing insurance in a geographical area averaged over the entire insured population. Compared to community-rated premiums, experience-rated premiums are lower for healthier groups and higher for those that are expected to have more health problems.

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80 *Business & Health*, January 1993, p. 35.

81 HIAA, 1991.

82 Community-rating is the practice of setting health insurance premiums based on the average cost of providing medical services to all people in a geographical area, without adjusting for each individual's medical history, occupation or likelihood of using medical services.

Biased selections occur as insurers are encouraged to seek and sign healthy consumers who will have less costly claims.[83]

While in most markets it is efficient for commercial insurers to charge premiums related to the risk presented by each group, risk selection problems in the health insurance market can produce significant equity problems. The practices of underwriting[84] and experience-rating for small groups often drive up the insurance premiums to such unreasonable levels for individuals and small groups with poor experience that millions of employed workers are not offered or can not afford any coverage for themselves or their dependents. Additionally, premiums are higher, in part due to significantly higher administrative costs for small groups.[85]

Commercial insurance companies are organized as profit-seeking firms or as mutual companies, which are legally owned by their policyholders. There is some evidence that the profit-seeking firms are more efficient.[86] The commercial insurers are able to compete by offering very good service and less complete coverage, which controls cost and utilization. Many consumers prefer less expensive, less complete coverage. Commercial insurance makes much more use of patient copayments than do Blue Cross-Blue Shield and is more conducive to effective competition and appropriate utilization. Even though the emerging trend is to reduce health insurance coverage and raise the financial responsibility of the consumer, there is still some commercial coverage that covers approximately 100 percent of hospitalization costs.

Blue Cross hospital and Blue Shield physician service plans, or "the Blues" are the largest and oldest insurance companies in the US, composing approximately 30 percent of the private insurance market with 72 plans nationally.[87] They are private, non-profit organizations that are locally governed. The market share of the Blues often varies greatly from one state to another.[88] In some states they have enough market power to extract special discounts from hospitals and physicians. The market power has been eroding, but the institutional environment established by the Blues remains.

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83 Greaney, 1988.

84 Medical underwriting is the process of determining a potential client's medical risk. It is most commonly found in the individual and small group insurance market, which only accounts for roughly 25 percent of all privately insured individuals (Danzon, 1992a).

85 "Firms with fewer than 50 workers incur administrative costs of about 25 to 40 percent of total claims, versus only 5.5 percent for firms with 10,000 or more employees" (*Economic Report of the President*, 1991).

86 Frech's 1980 study on efficiency found that profit-seeking insurers were most efficient, Blue Cross-Blue Shield insurers least efficient and the mutual commercial insurers in the middle (Frech, 1990).

87 Kenkel, 1992.

88 Their market share is over 70 percent in states such as Massachusetts and Rhode Island and under 10 percent in states such as Nevada.

The Blues often provide much more complete insurance coverage than commercial insurance companies. A great deal of Blues insurance, especially for in-patient hospital coverage, is effectively 100 percent full coverage. The Blues historically used their market power to encourage and promote relatively complete insurance. There is some use of patient cost-sharing where the consumer pays a deductible and has some type of coinsurance requirements.

The "Blues" are subject to different state regulation than commercial insurers. Blue Cross/Blue Shield insurance plans are quite often assessed lower premium taxes by the states, or exempted from them altogether. But, at the same time, the Blues are often required by state law to have open enrolment[89] periods and to offer individual and group policies, which give advantages to competitors and allow the Blues insurers to be adversely selected.

Self-insurance is another cost-control strategy used by many employers. By self-insuring, the employer bears the financial risk of health insurance coverage for its employees. As the costs of health care continue to increase, most American companies, including small firms, have opted to self-insure. Between 1986 and 1991, the number of employers who chose to self-insure rose from 46 percent to 65 percent, according to a recent study by A. Foster Higgins. Self-insured businesses do not have to pay health insurance premium taxes and avoid the costs of state-mandated benefits, high-risk pools, free-choice laws and other regulatory constraints. Under a self-insured plan, employers or labor unions provide medical coverage typically as a self-insured plan or a Minimum Premium Plan (MPP). In the former, the employer assumes all the risk for paying claims. In a MPP, the employer pays up to a specified amount, then a traditional insurer either pays or shares in the payment of any additional claims. The employer retains control over those funds until employees make medical claims. Most self-insured plans are major medical plans subject to a deductible and coinsurance requirements. Blue Cross-Blue Shield plans have been forced to use experience-rating to determine premiums for the types of groups that have the option of self-insuring.[90]

FAS No. 106: Medicare is the primary payer of health benefits for retirees age 65 and over, while employer-sponsored benefits are secondary. Employees retiring from US corporations in the future may see a decline in the retiree medical benefits once offered to their predecessors. The rising cost of providing benefits to retirees (and dependents) coupled with a new standard from the Financial Accounting Standards Board — FAS No. 106 — requires employers to account for the cost of future retiree medical benefits during their employees' years of service. The full impact that FAS No. 106 will have on retirees' medical plans is still unknown. One survey based on 2,409 employers nation-wide reported that two-thirds are raising retiree premium contributions,

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[89] Open enrolment refers to the time period when private insurers allow subscribers to change their current insurance and sign up with another insurer. Typically, open enrolment is only once a year.

[90] HIAA, 1991.

increasing cost-sharing and tightening eligibility requirements primarily to reduce their liability under FAS No. 106 and to contain retiree benefit costs.[91] Recently, General Motors Corporation announced plans to take a $20.8 billion charge against 1992 earnings to account for retiree health care costs as a result of this new rule.

1.3.3.1.2 Managed Care

As the cost of health care for employers began rising faster than profits, employers began pressuring insurers to help reduce their employee's health care costs. A new type of alternative delivery system — managed care — evolved as insurers began to compete to control the excessive use of high-cost medical care. In an effort to limit patients from over-consuming and providers from over-supplying, private businesses, insurance companies and governments have turned to managed care.[92] As a direct consequence, consumers of both public and private sectors now face a wide variety of insurance arrangements.

The term "managed care" encompasses a variety of innovations in both the delivery and financing of health care that are intended to eliminate unnecessary and inappropriate health care and reduce costs. Managed care can take on any or all of the following mechanisms: utilization review and control of decisions about health services provided, either prospectively or retrospectively, limiting or influencing patients' choice of providers, and negotiating different payment terms or levels with certain providers (i.e. discounts, capitation).[93]

Utilization controls can involve second surgical opinions, prior authorization for hospital admission, surgery or specialist services, the use of primary care physician "gatekeepers" who must be seen first to obtain referrals to specialist physicians, concurrent review of hospital use, discharge planning, and profiling of physician practices. These utilization management strategies may be used singly or in combination. Utilization control may lead to a refusal to pay for a particular service, establishment of guidelines for anticipated utilization (e.g. authorization for a specific number of hospital days for a particular diagnosis), or efforts to educate physicians whose practice patterns are assessed to vary substantially from accepted norms.

Traditional fee-for-service insurance has included various elements of managed care for some time now. Even before the introduction of DRGs by Medicare in 1983, insurers have used utilization review in the form of pre-certification and second opinions before surgery. In 1990, over 80 percent of conventional group insurance incorporated case management of high-cost illnesses and approximately 45 percent required pre-

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91 *Business & Health*, 1992.

92 Aaron, 1991.

93 Unless otherwise noted, all descriptions of managed care in this section were taken from US CBO, 1990.

admission certification and concurrent hospital review. There is a growing trend in the use of physician profiles as one component of utilization review, which was used by nearly ten percent of group insurers by 1990.

a. HMOs

The first HMOs were developed in the US during the 1930s and '40s. More recently, managed health care systems have exploded in size and population enrolment. The number of HMOs grew from 236 in 1980 to 550 in 1991.[94] At the end of 1991, approximately 15 percent of the US population (38.6 million people) was enrolled in HMOs[95] (see Chart 1.6). HMO membership has quintupled in the past fifteen years, from six million people in 1976 to nearly 30 million in 1990.[96] HMO membership is not evenly distributed geographically in the US and has not developed uniformly across the country.[97]

In 1973, the US Congress enacted legislation to promote HMO growth in The Health Maintenance Organization Act of 1973. Federal funds were authorized to establish and develop HMOs over a period of five years. Most employers were required to offer their employees an HMO option where federally qualified HMOs were available.

Although quite varied in form, all HMOs provide a pre-defined, comprehensive set of health services to a voluntarily enrolled population within a specified geographical area. HMOs are considerably more likely to cover preventive services in their benefit packages than are traditional indemnity plans. In an HMO, the focus is on the primary care physician who is the "gatekeeper" for the patient's access to specialist care, hospitalization and out-patient care.

Providers are typically reimbursed on a capitated basis or through some other "risk" arrangement.[98] These arrangements differ from traditional fee-for-service because the physician is put "at risk" for the utilization of health services by the patients. For instance, under a capitation arrangement, the primary care physician is given a fixed

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94 GHAA, 1992.

95 *Ibid.*

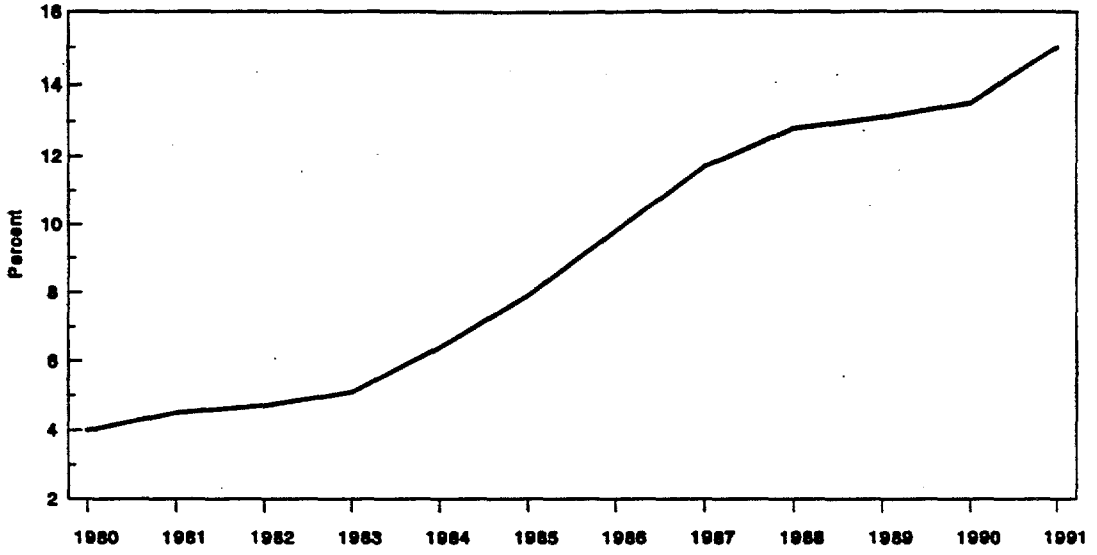
96 InterStudy, (1991 and 1992). In 1991, HMOs accounted for 27 percent of the 9 million person federal employee market, up from 18 percent in 1987 (US CBO, 1990). Only 3 percent of all Medicare enrollees and 10 percent of Medicaid recipients participate in HMOs (*Ibid.*). A major push is currently under way to persuade more people covered by public programs to choose managed care arrangements. To encourage provider participation, HCFA hopes to raise Medicare's maximum HMO average annual *per capita* cost payment from the current 95 percent ceiling to 100 percent of the cost for handling the average enrollee under the traditional Medicare plan.

97 HMOs are most likely found in areas with at least one million people and a large number of employed individuals in a few large firms.

98 Over 75 percent of all HMOs pay their physicians on either a captation or a salary basis (US CBO, 1990).

Chart 1.6

HMO Enrollment as a Share of U.S. Population



Sources: 1980-90, "The Interstudy Edge, Managed Care: A Decade in Review, 1980-1990"; 1991, "GHAA June 1992 HMO Fact Sheet".

dollar amount per member on his list per month. If the patient requires specialty care or hospitalization, the payment is made out of the capitated amounts (up to some stop-loss limit) or out of a set-aside "risk pool" of money. Thus, the physician must consider both the costs and the benefits of providing care to the patients.

There are a variety of HMO models that have evolved in response to the changing needs and desires of consumers, public and private payers, and providers. These include the group model, the network model, the staff model, the IPA model and the mixed or open-ended plan.

> *Group Model HMO:* Under a group model, the HMO insurer contracts exclusively with a single multi-specialty medical group. The medical group sometimes owns its own hospital. The group's providers are paid on a capitation basis. This type of HMO accounted for about ten percent of all HMOs but 27 percent of all HMO enrollees as of mid-1991.[99]
>
> *Network Model HMO:* In the network HMO, the HMO insurer contracts with two or more independent medical groups. The patient chooses a primary care physician from this network of contracted physicians. The primary care physician again acts as gatekeeper to obtaining access to medical specialists by controlling referrals. Providers are normally paid on a capitated basis, which

[99] InterStudy, 1991 and 1992.

puts them at risk for their utilization decisions. As of mid-1991, network HMOs accounted for about 12 percent of HMOs and 12 percent of HMO enrollees.[100]

Staff Model HMO: A staff model HMO integrates financing and delivery. The HMO insurer hires a staff of physicians to provide care under the insurers direct control. Sometimes, the staff HMO will vertically integrate by owning a hospital. The staff model accounts for about eight percent of HMOs and ten percent of HMO enrollees.[101]

IPA Model HMO: The Independent Physician Association (IPA) HMO contracts directly with independent physicians or with loosely organized associations of independent physician practices. These practices can include solo practitioners or group practices. IPAs are the most popular form of HMO model accounting for 62 percent of HMOs and 40 percent of HMO enrollees in mid 1991.[102] This form of HMO is common for solo physicians who are in private practice but want to recruit HMO patients to their offices.

Mixed HMO: Any HMO which is a combination of the above types of HMO.

The most recent innovation in managed care is the so-called "point-of-service", "hybrid" or "open-ended" option which has been appended to many HMO plans. Under this arrangement, the HMO allows patients to choose providers who are not authorized members of the physician or hospital panel for the HMO but requires the patient to pay an additional deductible, copayment or coinsurance if they choose non-panel providers. Open-ended HMOs provide greater freedom of choice to consumers yet still allow the HMO to control its costs of providing care. This type of plan is now the fastest growing form of HMO. Enrolment in open-ended HMOs has grown dramatically since 1986. In December 1986 there were 251,969 people enrolled in four open-ended plans. As of January 1991, over one million people were signed up with 116 HMOs offering open-ended plans.[103]

b. PPOs

PPOs are another managed care entity. Developed in the early 1980s, they are also growing rapidly in terms of both the number of organizations and total employees covered. In 1990, there were between 38 and 48 million employees who had access to

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100 *Ibid.*

101 *Ibid.*

102 *Ibid.*

103 *Ibid.*

some 820 PPOs.[104] PPO plans combine features of standard fee-for-service indemnity plans and HMOs. PPOs negotiate contracts with networks or panels of providers who agree to provide medical services and to be paid according to a discounted fee schedule. The provider gives a discount in return for the increased likelihood of patients being channelled to them through financial incentives; that is, if the patient uses a preferred provider, his coinsurance will be lower than if a non-PPO provider is used. Typically, insurers organize these arrangements, but sometimes providers or third-party brokers do. Ideally, providers are chosen to participate in the plan because their practice patterns satisfy pre-specified utilization criteria, assuring that care is efficiently provided and reasonably priced.

PPOs are more flexible than HMOs and provide patients with greater freedom in choosing a provider, but still try to achieve cost savings by directing patients to providers who are committed to cost-effective health care delivery. People who are enrolled in a PPO have the option to obtain health care from a non-affiliated provider, but they then must pay a higher share of the cost.

Like HMOs, there are various types of PPO arrangements which sometimes make the distinction between HMO and PPO difficult to discern. The extreme PPO is the exclusive provider organization (EPO) where services rendered in a non-emergency situation by a non-affiliated provider are not reimbursed at all. This form closely approximates the HMO form of managed care except for one important difference: providers are not put "at risk" for their utilization decisions through a capitation payment. In the EPO, providers are typically reimbursed on a fee-for-service basis according to a discounted fee schedule.

1.3.3.1.3 Administrative Costs

a. Difficulty in Definition

The role of administrative costs in health care financing looms as a major issue. From the point of view of economic efficiency, a desirable feature of a health care financing system is that it minimizes administrative costs.

A cross-country comparison of administrative costs involves calculating administrative costs as a share of total health benefits for each country. One could then conclude that the system with the lowest percentage is the most efficient provider of health care, (i.e. provides the highest benefit per unit of administrative cost). However, "[a] number of critical assumptions are implicit in comparisons of administrative spending among health plans or between countries. The most critical assumption is that each health

[104] HIAA, 1991. Varying definitions of the PPO plan used in surveys account for the differences in the number of PPOs and covered employees.

plan engages in the same administrative activities and pursues the same goals."[105] These underlying assumptions lead to significant problems in appropriately defining and measuring both the numerator and the denominator in the ratio of administrative costs to total health benefits.

A precise definition of administrative costs used in the numerator is difficult. Total administrative costs represent the sum of the deadweight losses associated with the provision of health insurance. Administrative costs include all costs incurred in the provision of health insurance coverage that are not directly attributable to the provision of hospital or medical care. Examples of administrative costs clearly include: filing claims, utilization review, marketing, general accounting and data processing. In general, estimates of these types of costs are obtained from accounting data. However, difficulties arise with regard to allocating costs between administration and other categories of expense. For example, a nurse may spend time on patient-billing activities, (administrative duties) as well as patient care activities. Time records often do not exist to determine the exact proportion of time spent even on these two broad categories of activities.

In addition, "[t]he true 'overhead' of a health insurance system also includes all of the hidden costs associated with financing and operating the insurance and with insurance-induced distortions in the production and consumption of medical care."[106] These hidden costs include social costs such as patient time costs, productivity losses and well-being. Such hidden costs are not captured by accounting data and are very difficult to measure accurately.

Similarly, quantifying the denominator presents a problem. Useful comparisons of administrative costs assume that the denominator, total health benefits, is equivalent across systems. This is not necessarily true. Since total health benefits cannot be quantified, a proxy must be used; for example, total health spending. However, this ignores potential differences in the quality of benefits provided.

b. Measurement and Comparisons

Much of the empirical work on measuring administrative costs to date has centered around the US health care system. The *Economic Report of the President* (1993) reports that in other countries with multiple insurers, such as Germany, administrative costs as a share of total health care expenditures are comparable to those in the US. In 1988, the Congressional Research Service undertook a comparison of administrative costs of private insurers within the US for customers of various sizes. Their results showed that administrative expenses as a percent of incurred claims decreased as the size of the firm increased. For firms with one to four employees, administrative costs were 40 percent

[105] Thorpe, 1992, p. 3.

[106] Danzon, 1992a, p. 40. Danzon is in the process of revising this article.

of incurred claims. The corresponding figure for firms with greater than 10,000 employees was 5.5 percent.[107] Even for the largest firms, administrative costs are higher than for the larger public insurance programs. Estimates of administrative costs as a percent of incurred claims for US public programs, Medicare and Medicaid, are 2.1 percent and 5.1 percent, respectively.[108] These results suggest administrative functions, as measured by accounting data, are subject to economies of scale. This has prompted efforts by private insurers to join together and realize these scale economies by using electronic information networks to reduce the administrative costs associated with processing medical claims. For example, in 1992 the Workgroup for Electronic Data Interchange (WEDI) a "group of insurance-company executives and health care representatives presented the Bush administration with a plan to bring the transactions of all health insurers under one computerized data network."[109] The group estimates that such a network would save at least $4 billion in administrative costs related to processing bills and claims.[110] In addition, HCFA has begun implementation of a standard data format for electronic processing of Medicare claims. The standard format provides financial incentives to health care providers to switch to automatic processing, enabling Medicare claims to be processed more cost effectively.[111]

c. Canada's "Hidden" Costs

Danzon asserts that existing comparisons of administrative costs in the US and Canadian health care systems are grossly misleading.[112] She identifies hidden overhead costs in the Canadian public insurance system that are difficult to quantify and omitted from any of the comparative analyses done to date. Further, she concludes that, when these hidden costs are correctly measured and adjusted for, overhead costs are actually higher in Canada than under private insurance in the US.

Hidden costs are derived from two major distortions in the Canadian single-payer system:

- rationing of care by other than price- or information-based methods; and

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107 Congressional Research Service, 1988, as cited in Danzon, 1992a.

108 Thorpe, 1992.

109 *Wall Street Journal*, July 22, 1992, B-1, 6.

110 In addition to a proposed national network, there are statewide efforts to reduce administrative costs through electronic claims processing. For example, a group of Kentucky insurers has launched a project designed to encourage medical providers to file health care claims electronically. Also, 14 Minnesota employers have formed a coalition in an effort to cut the costs associated with claims administration (*National Underwriter Life & Health/Financial Services Edition*, 1992a, p. 10 and 1992b, p. 20).

111 *National Journal, Government Executive*, 1992.

112 Danzon, 1992a.

- tax-based financing.

In the Canadian system, non-price forms of rationing generate hidden overhead costs in the physician and hospital sectors. Canadian physicians are paid on a fee-for-service basis with strict regulation of allowed fees. This form of physician reimbursement leads to a spreading of physician care over multiple, short visits.[113] The resulting increase in patient time costs, i.e. travel to and from appointments, time off from work, etc. are not measured in the accounting data as administrative costs but certainly should be included in any estimate of true overhead costs.

Canadian government's regulation of capital expenditures by hospitals reflects the government's commitment to control the rate of diffusion of medical technology. Thus, patients in Canada have less access to certain medical technologies than do patients in the US.[114] This contributes to the existence of waiting lists in Canada for various surgical procedures. Lack of immediate access to certain procedures generates costs to patients in the form of time costs, loss of productivity and reduction in quality of life due to discomfort, pain and/or suffering. Properly measured administrative costs should include these overhead costs.

Yet another hidden cost of public monopoly systems, such as Canada, is that they free-ride on R&D expenditures in the US.[115] Danzon (1992) states that this is most obvious in the case of pharmaceuticals but also applies to other medical technologies and information systems. And, "to the extent that US R&D spending benefits other countries that do not pay a 'fair' share of the joint costs, these hidden benefits should be credited against health care costs in the US in any comparison of real costs and benefits."[116]

The tax-based financing of the Canadian health care system creates additional hidden costs in the form of production and consumption losses. These losses occur because taxpayers alter their work, saving and consumption patterns to avoid activities subject to taxation.

Danzon attempts to quantify these hidden costs and concludes that "the costs associated with tax-based financing and rationing by other than price- or information-based

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113 This proliferation of physician visits is evidenced by the more rapid increase in utilization rates after the elimination of extra-billing. In the two years following Ontario's ban on extra-billing, services per physician increased by nearly 2.5 percent per year, contrasted with the average annual increase of 1.2 percent in the previous seven years (Lomas, *et al.*, 1989). Also, "Victor Fuchs and James Hahn report that in 1985 real resources used per physician visit were 34-46 percent lower in Canada than in the United States and that Canadians made more visits per capita" from Fuchs and Hahn, 1990, as cited in Danzon, 1992a.

114 Rublee, 1989.

115 Danzon, 1992a.

116 *Ibid.*

methods may be at least as great as the parallel costs of premium collection and claims administration incurred by private insurers."[117]

d. Competition vs. Monopoly

Measurement problems aside, economic theory provides insight into the relative costs of administering the following two types of health care financing systems: competitive private insurance and a monopoly public insurer. In a competitive market, all of the relevant costs of administering the system are internalized to the insurer. Therefore, the cost-minimizing competitive insurer has an incentive to minimize all relevant administrative costs for a given level of benefits provided. In contrast, in a monopoly public insurance system, many of the relevant administrative costs are outside of the insurer's cost minimization decisions. They become part of the general costs of operating government.

In a competitive market, buyers assess premium costs relative to total medical benefits. Therefore, competitive insurers will spend additional dollars on administration — utilization review, data collecting — only if this spending will result in a greater than proportional decrease in premiums or increase in benefits. With a monopoly public insurer, buyers have no choice of different premium/benefit combinations. Therefore, the insurer has no incentive to eliminate inefficient spending on administration. Since patients have no choice over their level of medical benefits, a monopoly public insurer has no incentive to consider fully all social costs in its administrative spending decisions, especially costs imposed on patients and providers. Due to these differences in incentives between a monopoly public insurer and competitive private insurers, properly-measured total administrative costs, for a given level of health benefits, will be lower in a competitive private insurance system.

1.3.3.2 Public Payers

1.3.3.2.1 Government

Local, state and national governments participate in the funding of health care services for the population primarily not covered by private insurance: the elderly, disabled, and poor. In 1990, all three levels of government combined spent $283 billion to fund medical and health care services, research, and medical facility construction. The governments' share represented more than 42 percent of total health care expenditures in the US in 1990.

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117 Danzon, 1992a, p. 39. For a criticism of Danzon's work, see Barer and Evans, 1992. The substance of their criticisms is that many of Danzon's conclusions lack sufficient empirical support. Danzon responds by reiterating the usefulness of economic theory in establishing a framework in which to compare the "overhead costs of a public monopoly versus a well-designed competitive private health care system", Danzon, 1992c.

In 1990, federal health spending totalled $195 billion, or a little over 29 percent of total health care expenditures. The majority of federal health spending is provided under six major programs: Medicare, Medicaid, FEHBP, CHAMPUS, VA and Indian Health Services.

a. Medicare

Since its inception in 1966, Medicare has evolved from a passive payer into an aggressive price setter willing to use its monopsony power to contain health care costs and federal budget deficits. Medicare is operated today as a single-payer health care system with administrative caps to control costs and utilization. The move to prospective payment of hospitals by DRGs has induced greater efficiency by hospitals but has also created revenue shortfalls in treating Medicare patients. As of 1992, physicians are also prospectively paid based on a federally set fee schedule which includes a global expenditure cap. These reimbursement changes reflect the US version of coping with the same public finance issue faced by other countries: accountability for public budgets forces governments to use their monopsony power no matter what the efficiency implications for the health care sector. Medicare now reflects the same administrative approach to financing health care as do the centralized systems of Canada, the UK, Japan and Germany.

b. Medicaid

Medicaid is a federal- and state-funded program administered by the individual states in the form of public assistance programs for low-income groups, families with dependent children, the elderly poor, and the disabled. Medicaid eligibility and benefits vary widely from state to state (see Table 1.1). Because the beneficiaries are predominately poor, the federal government prohibits balance billing and limits copayments to $1 per visit.[118]

Since the early 1980s, states have obtained waivers from the federal government to implement alternative reimbursement and cost control programs. Various states have set up "demonstration projects" that include capitation, case management by a primary care "gatekeeper" and limits on provider choice.[119]

The federal government's concern for the lack of pre-natal care and resulting high infant mortality rates among the poor has opened up the states' Medicaid programs to more poor women and children. Beginning in 1992, state governments were mandated by the Federal Government to accept higher levels of poor pregnant women and children under six years of age into their Medicaid programs. As a result, the states

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[118] Danzon, 1992b.

[119] *Ibid.* Some states, notably California, have realized substantial savings by switching to competitive bidding for hospital reimbursements.

Table 1.1
MEDICAID ELIGIBILITY STANDARDS FOR A FAMILY OF FOUR AND STANDARD AS A PERCENTAGE OF POVERTY LINE FOR A SELECTED GROUP OF STATES 1980, 1984 and 1986

State	Year	Eligibility Standard ($)[1]	Eligibility as a % of Federal Poverty Level
Alabama	1980	1,776	21
	1984	1,764	17
	1986	1,764	16
California	1980	7,800	93
	1984	9,612	91
	1986	11,208	100
Indiana	1980	3,780	45
	1984	3,924	37
	1986	4,356	39
New York	1980	5,712	68
	1984	7,224	68
	1986	8,484	76
Texas	1980	1,680	20
	1984	2,136	20
	1986	3,612	32
Average of All 50 States	1980	4,593	55
	1984	4,992	47
	1986	5,665	51
Federal Poverty Level, Family of Four	1980	8,414	100
	1984	10,610	100
	1986	11,203	100

[1] Eligible low-income poor must be in one of the categories of people covered under welfare cash payment programs - the aged, blind, disabled, and members of families with dependent children where one parent is absent, unemployed or incapacitated. Eligibility varies greatly among states.

Source: Davis, K., et al., (1990), Health Care Cost Containment, The Johns Hopkins University Press, Table 4.1.

have to bear an increasingly disproportionate share of Medicaid's payments, which grew by 20.7 percent from 1989 through 1990, the highest growth since the mid-1970s.

c. FEHBP

The largest employer-sponsored health care program in the US is the federal government's FEHBP, providing voluntary health insurance coverage for approximately

nine million federal government employees and their dependents in 1990.[120] The program is financed jointly by the federal government and increasingly by the participants, with the government paying approximately 74 percent of the average of all plan premiums.[121] FEHBP is available to all enrollees through a variety of private plans offering both varying levels of benefits and premiums. During the annual open enrolment period, FEHBP offers three major types of plans: (1) government-wide plans, which now only include a service benefit plan administered by the National Blue Cross and Blue Shield Association; (2) employee/union organization plans which are only open to member employees or annuitants; and (3) comprehensive medical plans, or HMOs, that offer health care by contracted physicians, hospitals and other providers in designated geographical locations.

d. CHAMPUS

CHAMPUS provides medical care to all active military personnel, retired personnel and their dependents, plus the dependents of deceased personnel, if they are not eligible for Medicare. CHAMPUS has conducted limited demonstration projects using managed care as the method of health care delivery. CHAMPUS recently announced that they will begin paying reimbursement rates based on Medicare's RBRVS in response to provisions received from Congress that require that CHAMPUS limit the increases in the maximum allowable rate paid to private physicians and reduce payment levels for some services.

e. VA

Medical care for those who served honorably in the armed forces is provided at 162 medical centers run by the VA. Patients with injuries and ailments related to military service receive priority. VA hospitals are generally funded on a global budget basis using government funds.

f. Native Americans

Lastly, there is a federal program designed to provide medical care and health services for more than one million native American Indian and Alaskan natives, called the Native American Services program.

g. State and Local Spending

The federal government has been attempting to control escalating federal health care spending and reduce its support for providing health care. As a result, the individual states are being left to carry more of the public health care bill. In 1990, expenditures

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120 HIAA, 1991.

121 *Ibid.*

from state and local spending — excluding Medicaid expenditures — totalled $33.9 billion, up from $5.5 billion (nominal) in 1970. State and local programs vary in the scope of services provided and the amount of financing available for these services, but can be generally divided into four primary program areas: personal health, environmental health, health resources and laboratory services. All levels of government are facing budgetary problems as fewer resources will be available to provide for the growing health needs of an aging population.

1.3.4 The Physician Health Care Sector

Physicians indirectly control over 70 percent of all health expenditures through their decisions on behalf of patients regarding hospitalization, testing and treatment with medicines.[122]

There has been an increase in the number of physicians relative to the US population over the past two decades — from 1.6 per 1,000 population in 1970 to 2.4 per 1,000 in 1990.[123] Today, there are more than 600,000 active physicians in the US, a 30 percent increase since 1980.[124] The number of doctors is growing three times faster than the general population.

Average real physician incomes for self-employed physicians grew by 24 percent from $125,500 in 1982 (1989 dollars) to $155,800 in 1989.[125] Pope and Schneider (1992) report that most of physician income gains in the 1980s were due to higher average hourly earnings, and relatively less due to greater work effort. US physicians earn a higher personal income than their colleagues in other countries. In 1987, the average real income of physicians in the US was $132,000 compared to $83,000 in Canada, $82,000 in Germany, $45,000 in Japan and $41,000 in the UK.[126] Some of the difference is probably due to differences in who bears the cost of training and some is explained by the added costs of malpractice insurance for US physicians.

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122 Davis, *et al.*, 1990.

123 US CBO, 1991.

124 Taylor, *et al.*, 1991.

125 Pope and Schneider, 1992. Between 1983 and 1990, US physicians' average annual income increased by 60 percent while the national average income only increased by one percent (Taylor *et al.*, 1991 and AMA, 1992b).

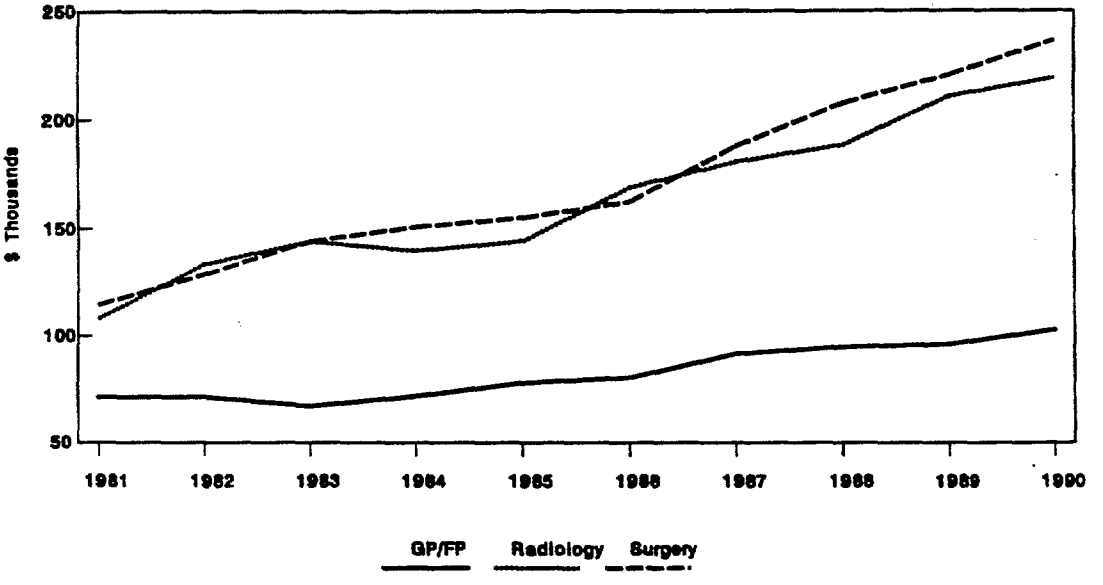
126 US CBO, 1990. OECD data adjusted according to purchasing power parity.

1.3.4.1 *Specialists*

Over the past two decades the physician population has become increasingly dominated by specialists.[127] The proportion of specialists to generalists in Canada, the United Kingdom and New Zealand varies from 25 to 50 percent while this proportion in the US is upward of 70 percent.[128] Specialists in the US earn higher incomes and can therefore repay high levels of medical school debt[129] faster, work fewer hours, and have the potential to earn a great deal of prestige (see Chart 1.7). These represent the major reasons why many new doctors choose to specialize.[130] Strong evidence is emerging that suggests the US has a plentiful supply of specialists. General and family practice physicians increased 9.9 percent from 1983 to 1990, whereas medical specialists increased 23.1 percent during this period.[131]

Chart 1.7

Selected U.S. Physician Incomes* 1981-1990



** Mean net income after expenses, before taxes.*
Source: AMA Socioeconomic Characteristics of Medical Practice, 1987 and 1992.

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127 Between 1980 and 1988, there was a 30 percent growth rate in the number of medical specialists and a 17 percent increase in general medicine and family practitioners (Taylor, *et al.*, 1991).

128 Schroeder, 1992.

129 Unlike Canada and other industrialized countries where medical education is highly subsidized by the government, upon graduation the American medical school student faces an average medical school debt of $46,000 (*LA Times*, July 16, 1992).

130 Only 14.2 percent of all 1992 medical school graduates are planning careers in primary care (Pallarito, 1992b).

131 AMA, 1992b.

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1.3.4.2 *Malpractice*

Malpractice premiums are a component of providers' costs. Danzon reported that "[m]edical malpractice insurance premiums of physicians and hospitals totalled 1.1 percent of total health care expenditures in 1975 and 0.74 percent in 1982."[132] In 1990, mean professional liability insurance premiums for self-employed physicians totalled 8.8 percent of mean physician net income.[133] The mean liability premium level paid by physicians varies greatly among practice areas — in 1990, obstetricians / gynaecologists paid $34,300 per year while psychiatrists paid only $4,500 per year.[134]

Malpractice premiums have risen dramatically over the years. The AMA reports that malpractice premiums for self-employed physicians rose at an average annual rate of 18.3 percent between 1982 and 1988.[135] Increased malpractice premiums make up a higher proportion of physician revenues, from 3.1 percent of practice revenues in 1982 to 5.6 percent in 1988.[136]

The threat that patients will sue physicians for malpractice leads physicians to provide marginal, unnecessary or inappropriate care.[137] The ten most frequent physician malpractice allegations in 1990 included:

- surgery/post-operative complications;
- failure to diagnose/cancer;
- improper treatment/birth related;
- improper treatment/insufficient therapy;
- surgery/inadvertent act;
- improper treatment/infection;
- improper treatment/during examination;

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132 As quoted in Aaron, 1991, p. 45.

133 Mean net income is after expenses and before taxes.

134 AMA, 1992b.

135 US CBO, 1991.

136 *Ibid.*

137 An AMA publication reported that as many as 75 percent of all doctors feel threatened and provide this type of defensive care (Taylor, *et al.*, 1991).

- improper treatment/drug side effect;
- failure to diagnose/circulatory problem/thrombosis; and
- failure to diagnose/fracture or dislocation.[138]

Thirty-eight percent of physicians have incurred at least one liability claim in their career.[139] The AMA (1992b) reports that there is a levelling off in the frequency of professional liability claims — from 10.2 per 100 physicians in 1985 to 7.7 per 100 physicians in 1990.

1.3.4.3 Practice Variations

The practice of medicine and the use of most medical procedures varies dramatically from region to region. Wennberg's "small area variation" studies have shown that in geographical areas with the greatest supply of physicians and hospital beds to fill more of these services were utilized. Phelps (1992) attributes these "variations" to the problem of incomplete diffusion of medical information found in the "difficulties in collecting information about the success of medical procedures; difficulties in establishing property rights to such information; and liability considerations that hinder adoption of any information that is collected." A great deal of variation also exists in the fees physicians charge. For example, in 1990 the median physician fee charged for the first office visit to a family practitioner in the west was $111, while the charge for the same visit was $75 in the south (see Table 1.2).[140]

1.3.4.4 Physician Satisfaction and Autonomy

In a recent survey, US doctors were found to be much less satisfied with the US health care system than Canadian and Western German doctors were with their health care systems.[141] US doctors were particularly concerned about treating people without health insurance or other means of paying for care. Over half of the US doctors surveyed said that these patients came to them too late to administer appropriate care.

Physicians are beginning to lose much of their autonomy previously enjoyed under a predominantly fee-for-service reimbursement system. The cost containment measures practised by existing managed care plans make use of medical review companies to evaluate medical treatment decisions and now require second opinions on surgery and

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138 AMA, 1992b.

139 Taylor, *et al.*, 1991.

140 HIAA, 1991.

141 Reported in a recent poll of American, Canadian and West German physicians conducted by Louis Harris and Associates between February and May 1991, *The Wall Street Journal*, June 6, 1992, p. B4.

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Table 1.2
MEDIAN US PHYSICIAN FEES FOR OFFICE VISITS BY REGION AND SPECIALITY
1990

Speciality	First Office Visits ($)				Office Revisits ($)			
	West	Midwest	South	East	West	Midwest	South	East
Family Practice	111	76	75	N/A	45	33	34	N/A
General Practice	100	61	61	61	40	31	32	33
Internal Medicine	137	91	98	101	48	40	40	48
Obstetrics / Gynaecology	95	61	64	76	50	40	41	51
Paediatrics	81	46	49	55	42	33	33	40

N/A - indicates not available.

Source: HIAA Source Book of Health Insurance Data, 1991, Table 4.13

other medical procedures. Physicians are also losing their control over the pricing of medical services. Changes in Medicare billing rules, which are also being adopted by many large private insurers, restrain the rate of growth in the fees charged by specialists. These measures have decreased the provider's medical prerogatives and have made him more responsible to both patient and payer.

Physicians and hospitals are responding to governmental and private insurer cost-containment policies by seeking strength in numbers. Between 1980 and 1988, the number of physician group practices grew by 54 percent, or 10,762 to 16,579.[142] This trend, in part, reflects the greater control of physician schedule and the greater ease that group physicians have in negotiating contracts with managed care contractors.

1.3.4.5 Reimbursement

Physicians in the US are reimbursed through a variety of methods that produce different incentives in the physician's delivery of health care. The physician reimbursement system has changed dramatically over the last two decades. With private insurance coverage, traditional fee-for-service provides an incentive to perform almost any service which will be of any benefit to the patient, including high-cost services with low expected benefit to the patient. Managed care programs make use

[142] PROPAC, 1992.

of capitation payments and discounted fixed fees and expose physicians to varying levels of financial risk. Medicare's RBRVS has replaced the physician-set fee-for-service reimbursement with a uniform national fee schedule structure. The RBRVS system has also shifted reimbursements toward favoring time-intensive diagnostic and primary care procedures rather than specialty care and high-technology diagnostic and therapeutic services.

Managed care insurers negotiate with providers for lower prices or different payment arrangements in various ways. For example, physicians may enter into a capitated arrangement by which they receive a fixed payment per patient covering a specified set of services for a specified time period. When providers are capitated, managed care insurers can budget more easily for the costs of these services. In addition, since providers are at risk for costs that exceed the capitation payment, providers receive incentives to offer fewer services than under a fee-for-service reimbursement system. Other managed care organizations seek discounts from standard fee-for-service charges from providers in exchange for an increased volume of patients. Providers may also be offered a bonus related to profits or surplus revenues which result when utilization is kept low. Alternatively, they may pay a penalty in terms of a portion of the providers payment which is withheld if they exceed a pre-specified target for use rates or expenditures. Capitation combined with a risk-sharing arrangement covering hospital and specialist care creates the strongest incentives for providers to limit unnecessary and inappropriate care. Discounts from standard fee-for-service charges reduce per unit costs, but do not necessarily change providers' practice patterns.[143]

Physician incentives have changed as a result of the managed care approach to health care in the US. As managed health care systems grow, it is the primary care physician who is in demand. In a typical HMO setting, primary care physicians act as "gatekeepers" with financial incentives to reduce utilization of specialized services and hospitalization. The increasing power of the primary care physician is also evidenced by the new RBRVS fee schedule which generally favors primary care over specialty care.

Managed care has also changed physician prescribing practices for pharmaceuticals. HMO plans in the US are increasingly relying on the use of mandatory drug utilisation review, formularies, generic substitution, therapeutic interchange and step therapy. Recent surveys show that the steady growth of prescription drug cost-containment programs is directly attributable to increases in both drug prices and the cost of drug therapy. According to Group Health Association of America (GHAA), 70 percent of all HMOs that offer pharmaceutical benefits rely on some kind of restrictive formulary and generic substitution is widespread.[144]

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143 US CBO, 1991.

144 GHAA, 1992.

Under the initial Medicare physician reimbursement system in place until the beginning of 1992, physicians were generally reimbursed for their "usual and customary" fees.[145] This form of reimbursement soon became the norm for other third-party payers as well. Physicians were paid to provide more care, conduct more tests and prescribe more medicines.[146] The health care system that resulted has an imbalance in procedural services over primary care.

To gain better control over escalating health care costs for physician services provided under Medicare, the government radically changed its method of reimbursing physicians in 1992. By adopting the RBRVS fee schedule system, reimbursements are now based on the resources used in each type of physician service, adjusted geographically only for cost differences.[147] The new fee schedule is intended to narrow the income gap between generalists and specialists by raising the Medicare reimbursement for procedures normally performed by primary-care physicians and slowing the growth in fees for specialist-oriented procedures.[148] The new RBRVS fee schedule is the first attempt to control aggregate Medicare spending for physician services by reducing payment rates for particular services if overall spending rises too fast. Due to the structure of RBRVS reimbursements, the incomes of primary care physicians are likely to increase and the incomes of specialists are likely not to increase as fast or decrease over time. Changes in physician incomes will undoubtedly be more profound if other payers adopt similar reimbursement systems for physicians.

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145 Only in 1973 were physician fee increases limited by the government by the rate of inflation in an attempt to contain health care costs.

146 Provider-induced demand is a controversial issue in the US medical system. It is difficult to determine whether more services are provided to patients because these services have a positive benefit to consumers or simply because patients can be duped to earn more income for physicians. However, recent issues involving self-referral suggest the continuing need for utilization review. Many physicians have a financial interest in many of these laboratories, diagnostic and therapeutic centers, and clinics and refer patients for treatment to these facilities. A study by professors at Florida State University found that at least 40 percent of physicians in Florida had financial investments in such facilities. The physician-owned laboratories performed twice as many tests per patient than independent labs. In another study performed with private health insurance claims, University of Arizona researchers found that physicians who had diagnostic imaging equipment in their offices ordered four times more imaging exams than doctors who referred patients elsewhere for the tests. In addition, there are also several allegations where self-referral has turned into fraud. More and more states are beginning to set limits on the levels of financial interest physicians are allowed to hold and the percentage of procedures authorized to be performed. In defense of such practices, some equipment might not be available in relatively isolated areas without physician investment.

147 Each physician service has a pre-determined relative value based on the following three components: physician time and intensity in providing the service, practice expense reflecting overhead costs (other than malpractice costs and physician compensation), and malpractice expense associated with the service. Physician fee schedules include the services of dentists, podiatrists, optometrists, and chiropractors, to the extent that their services are covered by Medicare. Also included are out-patient physical and occupational therapy, diagnostic tests and radiation therapy.

148 HCFA estimates that over the initial five-year phase-in period of the new fee schedule, reimbursement will increase 125 percent for family practice physicians, compared with 59 percent for cardiologists (Weissenstein, 1992).

Emphasis in managed care on general practitioners and RBRVS will produce fewer financial incentives to specialize.

1.3.5 Hospital Sector

Hospitals in the US are organized as government (federal, state and local), not-for-profit or for-profit providers. There are those that serve the general population and others that serve specific populations such as veterans or native Americans. There is also a distinction among hospitals in terms of length of stay. Short-term hospitals generally treat patients for acute conditions defined as stays of 30 days or less. Long-term hospitals treat patients for chronic problems requiring less intensive care. Hospitals can also be classified as general acute care (often the role of community hospitals) or specialized according to the type of medical treatment they provide. Hospitals providing care to the general population are organized as either for-profit or not-for-profit firms. The majority of the acute care hospitals are not-for-profit institutions run by a board of directors. Cost containment pressure make all hospitals behave as profit maximizing firms regardless of status (for-profit or not-for-profit).[149]

1.3.5.1 Changing Structure

During the 1980s, the hospital industry changed dramatically. Today, US hospitals produce relatively short but medically intense hospital stays and perform a little over half of all surgeries on an out-patient basis because they are less expensive and not subject to DRGs.[150] Since 1980, in-patient admissions have declined by 13.1 percent and out-patient visits have increased by 40 percent.[151] In 1990, the nation-wide occupancy rate for community hospitals was 66.8 percent, down from 76 percent in 1980.[152] The change to negotiated rates and prospective payments, which helped to produce these lower occupancy rates, has also resulted in an unprecedented number of hospital closures. Between 1980 and 1991, 603 acute-care hospitals closed, an average of 50 per year.[153] As an alternative to closing, many hospitals have chosen to broaden their focus to include the delivery of out-patient services such as drug and alcohol treatment, rehabilitation services, urgent care centers and home health care.[154] Other hospitals have merged to avoid closure.

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149 Not-for-profit does not mean a lack of profits. This status mainly reflects that the firm has a constraint on the distribution of its excess revenues over costs.

150 AHA, 1992b.

151 AHA, 1991, 1992b.

152 AHA, 1992b.

153 Burda, 1992.

154 Blendon, and Edwards, 1991.

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1.3.5.2 Hospital Managers and the Roles of Physicians

Hospital managers are generally responsible for hospital revenues and costs. They have some influence over the types and amounts of services provided within the hospitals they manage through their control of purchasing and staffing decisions. However, physicians, both general practitioners and specialists, are independent suppliers of health care both within and outside of the hospital. Specific decisions on services for patients are not under the control of the hospital manager except as he must assure quality (avoid lawsuits). The hospital manager's incentives are to attract physicians by keeping the patients and admitting physicians happy. The role of the hospital manager is constantly challenged by fewer hospital admissions and shorter length of stays. The hospital industry is by and large very competitive; those hospitals that cannot meet their costs either merge or close.

In the US, physicians apply for privileges to admit and treat patients at the hospitals of their choice. The general practitioner or the specialist may admit the patient. Once in the hospital, most decisions are made by the specialist. There are two types of specialists. Hospital-based specialists provide services such as emergency room care, radiology, anaesthesiology and pathology to the admitting physician's patients. These hospital-based physicians are often paid under a contract with the hospital, which allows the hospital manager to assure the smooth provision of these services. Other specialists are independent practitioners who are often paid on a fee-for-service or discounted fee-for-service basis. Most managed care plans do not negotiate capitation contracts with specialists, with the exception of some capitated contracts for outside laboratory services.

Most physicians maintain their practices as legally independent entities from hospitals. The hospital-based physician is paid in a variety of ways. In 1990, 51 percent of all hospital-based physicians were paid on a salary basis and 30 percent on a fee-for-service basis.[155] The hospital-based physician has administrative duties within the hospital as well as medical duties. The number of hospital-based physicians has been declining over the last decade. In 1981, 26 percent of physicians had some form of hospital contract, while only 19 percent had such a contract in 1990.[156] The decline reflects changing Medicare reimbursements, the growth in alternative practice settings, and the flat income growth derived from such contracts.[157]

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155 AMA, 1991.

156 *Ibid.*

157 *Ibid.* Incomes derived from hospital-based contracts was approximately the same in 1981 ($59,000) and 1990 ($59,400), while average total revenues per physician increased over 50 percent during this same period (*Ibid.*).

1.3.5.3 *Reimbursement*

The last decade has witnessed significant changes in the methods utilized to reimburse hospitals. The retrospective, cost-based payments, which encouraged rapid expansion and resulted in excess capacity, have generally been replaced with various prospective payment arrangements. Hospital funds come from Medicare's fixed payment per diagnosis (DRG) or *per diem* rates and cost-per-case rates negotiated with various governmental agencies and managed care entities. List prices set by the hospital now represent a shrinking proportion of hospital reimbursements, especially in those states with substantial managed care penetration. Large buyers of hospital services (HMOs) now negotiate substantial discounts from list prices. A small number of government hospitals are paid on a global budget basis.

Hospital expenditures grew rapidly in response to the cost-based reimbursements. Hospitals were able to expand their services by adding new technology. This resulted in progressively more expensive medical equipment being used by physicians to perform more tests and procedures on a greater number of patients.

In 1983, Medicare introduced a new method for paying hospitals to replace reimbursement of actual costs with a system of prospective rates based on the patient's diagnosis. The system establishes two separate sets of prospective rates (one each for urban and rural hospitals) for 467 diagnosis-related groups — that is, groups of patients with similar medical conditions. The payment is based on a mixture of the regional rates, the national rates for whether the hospital is rural or urban, and whether the hospital is a teaching hospital. If a hospital's cost are less than the fixed rates paid by the government, then the hospital keeps the profit. If they are more, then the hospital absorbs the loss. The federal government's goal in establishing DRGs was to slow the growth in Medicare's expenditures for hospital care, which had expanded from $5 billion in 1970 to $37 billion in 1982.[158] Hospitals were expected to become more efficient and provide greater use of alternative kinds of care given the change in reimbursement.

The federal government exempted a few states with their own rate-setting programs from the DRG legislation and allowed them to continue operating these reimbursement systems.[159] The states of New Jersey, Maryland, New York and Massachusetts created all-payer systems to prevent cost shifting among payers. All-payer systems expanded the rate-setting to include Medicare and privately-insured patients as well. There is evidence suggesting that state mandatory rate-setting programs slowed the rate of increase in hospital costs by an estimated three percent, at least in the short-run.[160]

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158 Gibson, *et al.*, 1984, compiled US HCFA data for 1983.

159 Russell, 1989.

160 Davis, *et al.*, 1990.

Several other states did not have Medicare DRG waivers, but did implement partial-payer systems to regulate the rates paid to hospitals by one or more payers other than Medicare. Rate regulation may have some short-term effect on controlling costs of individual services, but it also reduces quality of hospital care and may actually increase the quantity of care consumed, especially in an out-patient setting.[161]

In an effort to recoup relatively low payments received for treating certain publicly insured populations, hospitals have been forced to "shift costs" to traditional commercial insurers. The federal government reimburses hospitals for only about 90 percent of the cost of caring for a Medicare patient, while Medicaid reimburses about 80 percent of the costs for a Medicaid patient, leaving patients with private insurance charged 128 percent of the costs of a hospital stay.[162] As insurers compete to control moral hazard and keep premiums low, innovations in managed care have made it more and more difficult to "shift costs" to these insurers. That is, there is a growing realization by insurers that their ability to guarantee health care providers a flow of patients gives them a powerful position in negotiating rates with providers. Large insurers are now exerting whatever buyer-power they possess in a local hospital market generally suffering excess capacity.

1.3.5.4 Certificate-of-Need Programs

In the 1970s, capital spending controls were undertaken, which created planning agencies to review and approve all hospital plans for expanding or otherwise altering the physical structure of the hospital based on need. All states receiving federal health resources were required to enact Certificate-of-Need (CON) laws. By 1980, all states except Louisiana had enacted such laws. CON programs did little to restrict hospital growth because there was no expenditure limit put on total spending. In addition, "CON programs in most states were applied in an erratic and politically motivated way that was not consistent with cost-consciousness and the orderly adoption of new technologies."[163] CON programs appear to increase total hospital costs relative to hospitals without such laws and function as a barrier to entry into hospital markets, inhibiting competition. Prices for hospital services are likely to be higher as a result of CON programs.[164] In 1986, CON requirements for states to receive federal funds were dropped. By 1991, eleven states had eliminated their CON programs.

Currently, the states of Vermont and Rhode Island use the CON process to help enforce a system of global budgets. CON laws are used as a vehicle to make allocation decisions while staying under a spending cap. Rhode Island has seen a 50 percent

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161 Sloan, 1984.

162 PROPAC, 1992.

163 US CBO, 1991, p. xvii.

164 Sherman, 1988.

decline in the rate of approved capital expenditures since CON laws have been used with global budgets beginning in 1984.[165]

1.3.5.5 Effects of Competition

The existence of excess capacity in the hospital sector has provided incentives for hospitals to negotiate discounts to managed care plans in exchange for incremental increases in patient volume. Hospitals compete on the basis of price, as well as quality, for selective contracts with certain managed care plans and self-insured employer groups.[166] The rapid growth of managed care organizations in large communities who selectively contract with hospitals to negotiate lower prices has enhanced price competition.[167] Melnick, *et al.* (1992) emphasizes that the effectiveness of selective contracting as a cost and price control mechanism is highly dependent on the existence of a sufficient level of competition in the market. Competition in the hospital sector can lead to lower prices for major purchasers.[168]

1.3.5.6 Patients

The US system provides a great deal of patient choice in the selection of a hospital. Choice of hospital is primarily based on location and reputation.[169] Under a fee-for-service reimbursement arrangement, the patient is completely free to choose a hospital he desires subject to his physician's admitting privileges. Of course, a patient could choose a hospital and, then, find a physician with privileges at that hospital. Most hospitals provide referral services to physicians affiliated with their hospital. The patient merely calls the hospital for a referral.

In a managed care system, there is usually a pre-existing contract with a hospital where the managed care patient will be admitted if the primary care physician decides it is necessary. Many patients who participate in a particular managed care arrangement base their decision to do so, in part, upon the designated hospital in the managed care contract.

Hospitals set their own prices but are increasingly forced to negotiate discounted prices with individual payers. Many state governments negotiate prices for hospital services

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165 *Medicine & Health*, February 22, 1993.

166 AHA, 1992c.

167 A recent report by the US CBO notes that, unless managed care is the dominant form of hospital financing in a given market, the "price competition" derived from managed care discounting will intensify cost shifting to other private purchasers (US CBO, 1992a).

168 Melnick, *et al.*, 1992.

169 Reputation is very difficult to measure. A patient may rely on the suggestion made by his physician, the credentialling effect of managed care contracts, what he has read, or, merely by soliciting advice from friends or relatives.

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