Financial Innovations in Medical Insurance of the Russian Federation

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Abstract

Currently, the main sources of financial support of Health of the Russian Federation are budgetary funds, funds of health insurance and personal funds of citizens, and businesses in various ratios. Compulsory health insurance in the transition to single-channel financing of the health system has become the main mechanism for ensuring the constitutional rights of citizens to receive free medical care. Demographic indicators and their development trends, as well as the current economic situation, do not allow public authorities to comply fully with their obligations to ensure public health care. Lack of financial resources makes declarative nature of the state guarantees, which remain unsecured with financial resources. Formation of market relations in health care manifested in the implementation of elements of entrepreneurial activity, and in the event of a significant increase in the volume of paid medical services in the development of voluntary health insurance. Market conditions require an evaluation of the real possibility of state involvement in the financing of the national health system through the compulsory health insurance and additional sources of funding. The system of voluntary health insurance is a reserve development, which is currently used insufficiently.

Keywords: financial innovation, health financing, health insurance, redistribution of financial liabilities.

1. Introduction

1.1 Introduce the Problem

Financial economics of the public sector, to which the national health care is directly related, relates to the problem of choice. Within the public sector, as in any other sector of the economy, there is a constant selection at the allocation of resources. State resources generated from miscellaneous income, are limited in quantity and the distribution of the directions, one of which acts as the financing costs for the provision of free medical care.

Needs of the population in health care shall be provided with financial resources, regardless of the source of their sources. The transition to single-channel financing is the basis for the implementation of financial innovation in the field of

health insurance, to balance the state obligation to provide medical care to the population through the redistribution of financial commitments between public and private sources.

1.2 Importance of the Problem

The theoretical significance of the study is to justify the necessity and feasibility of financial innovation in the field of health insurance of the Russian Federation and the development of factor reallocation of financial obligations towards the revision of the standard state guarantees of free medical care and the expansion of health care co-financing.

1.3 Relevant Scholarship

Results of the study were discussed at the international and national scientific conferences, as well as through public lectures by Summer School of the European Days of Science "Health Economics". The main provisions were submitted and approved by the Federation Council Committee on Budget and Financial Markets. The study materials are used by the Department of Insurance in the learning process of the Ural Federal University named after the first President of Russia B. N. Yeltsin. In addition, they are used in the activity of the Territorial Mandatory Health Insurance Fund of the Sverdlovsk region and the medical insurance company ASTRAMED-MS.

1.4 State Hypotheses and Their Correspondence to Research Design

Distribution of state resources between the health sector and other areas (national defence, national economy, environment, education, social policy, etc.) can be produced using the production possibility curve (curve transformation) (Figure 1). Production possibilities curve reflects the different states the volume ratio of resources allocated to the health sector and other areas.

Figure 1 shows the production possibilities curve for medical services A and other goods B to the various possible combinations of production and provision. As we move from point C to point D on the production possibility curve of the state, the number of medical services A will decrease and the amount of other goods B will increase. Any point on the production possibility curve reflects the distribution of state resources, which is characterized by the fact that it is impossible to increase the provision of medical services A without loss of production and the provision of other goods B.
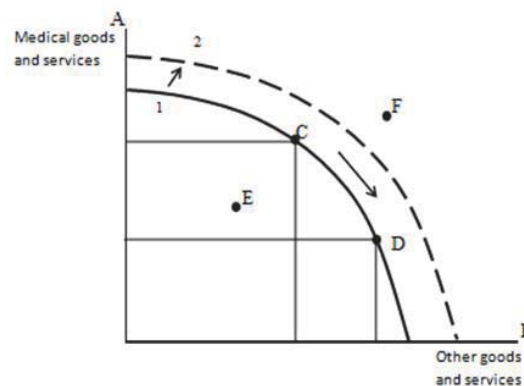
Figure 1 - Production possibility curve of the state, reflecting the ratio of production and delivery of health services and other goods with limited resources

For example, if the government wants to provide the public with more free medical services A, it will be necessary to give up part of other goods B, because the available resources are limited. If an increase in spending towards health decline in spending in other areas is not desirable, it is necessary to increase the total amount of available resources (production possibilities curve of the state shall move from position 1 to position 2), which is not always possible.

The points characterizing the volume ratio of the distribution of available resources, below the production possibility curve of the state (for example, point E in Figure 1) will reflect inefficient use of available resources. When this ratio has the opportunity to state for the same amount of resources to provide more health care services as A, and other goods B.

Points outside the production possibilities curve States (for example, point F in Figure 1), this ratio will reflect the volume of distribution available resources that can be called unattainable in the current circumstances.

The condition of the limited resources available draws attention to the question of the cases in which the state must take responsibility for ensuring that the company health services, and in some cases it is possible to receive these benefits from private producers. There is an issue of choice as the allocation of the available resources between the health sector and other areas, as well as in determining what amount of medical services can be provided to the public free of charge at the expense of public resources generated from tax revenues and insurance premiums, and how much can be obtained by citizens through personal funds in the private sector of health care.

Implementation of financial innovation in the field of health insurance, will allow the private sector to take into account when assessing the production capacity. Figure 2 shows the curve of the total capacity of public and private sources of health financing. Private funding of medical services does not affect the maximum amount of goods and services that can be produced and provided in sectors other than health, as demonstrated in the chart. However, they increase the total volume of medical services that can be provided to the population using public opportunities in conjunction with the private sector in health care.

In the case where not taken into account the possibility of private health care financing, the volume of medical services is at point A, other goods and services - at point B. When taking into account the range of possible (point I on the curve of the total possibilities) provision of health services is moving from point A to point A_1, the amount of other goods stored in the point B.
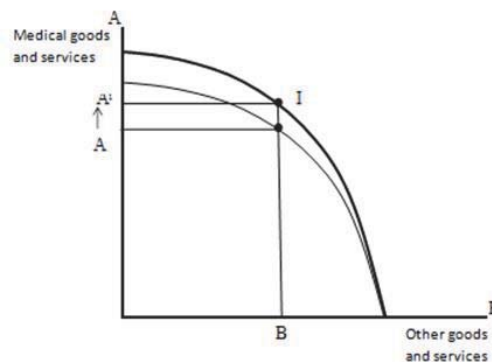
Figure 2 - The curve of the total capacity of public and private sources of health financing.

The advantage of using private sources of health care financing, since maintaining the level of public resources allocated to health, increasing the total amount of health care services that can be provided to the population at the expense of their personal funds, are obvious.

Financing of health care system of the Russian Federation shall be based on the program of state guarantees of free provision of health care to citizens. The program is a system of state guarantees instrument designed to balance the state's obligations to provide the population guaranteed medical care. Public authorities of subjects of the Russian Federation in accordance with the program of state guarantee the development and approval of the territorial programs.

The continuing lack of financial support for regional programs makes a real need to reduce government liabilities for guarantees of free medical care. The revision of per capita financial support of free medical care, which can be provided to the population under the terms of reimbursement through the system of voluntary health insurance and the provision of paid medical services, seems acceptable.
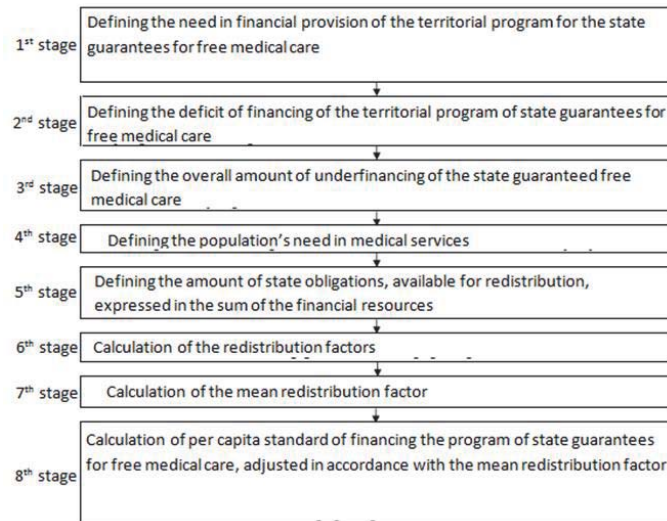
2. Method

2.1 Method of statistical monitoring

In the course of the study, the authors used an analytical, logical-structural approaches use statistical and graphical methods for processing and reporting, as well as the comparative economic and scenario analysis.

2.2 Method of analysis and measurement

In this study, the authors developed a factor of redistribution of financial obligations in the field of health insurance between public and private sources in the direction of the revision of standard state guarantees of free medical care and the expansion of co-financing of health (Figure 3).

1st stage	Defining the need in financial provision of the territorial program for the state guarantees for free medical care
2nd stage	Defining the deficit of financing of the territorial program of state guarantees for free medical care
3rd stage	Defining the overall amount of underfinancing of the state guaranteed free medical care
4th stage	Defining the population's need in medical services
5th stage	Defining the amount of state obligations, available for redistribution, expressed in the sum of the financial resources
6th stage	Calculation of the redistribution factors
7th stage	Calculation of the mean redistribution factor
8th stage	Calculation of per capita standard of financing the program of state guarantees for free medical care, adjusted in accordance with the mean redistribution factor

Figure 3 - Stages of determination adjusted for the redistribution factor of capitation financial provision of medical care to the population of the Russian Federation

2.3 Taxonomic method

The need for financial support of the territorial program of state guarantees of free medical care (T) may be represented as follows:

$$T = A + B + C, \quad (1)$$

where A is the federal budget means of the Russian Federation;

B is the consolidated budget means of the Russian Federation;

C is the means of the compulsory health insurance system.

The need for financial support of the territorial government guarantee program is calculated on the basis provided by the federal program standards based on demographic characteristics, the level, and structure of morbidity of the population of the Russian Federation. Any demographic changes shall be reflected in the territorial programs of state guarantees.

The Programme of state guarantees standards are guaranteed and cannot be reduced to the level of the subject of the Russian Federation in the development of regional standards, i.e.:

$$N_1 \leq N_2, \quad (2)$$

where N_1 is federal per capita quota financial security;

where N_2 is territorial per capita quota financial security;

Balance condition territorial program in terms of guarantees and their financial security needs implies equality and actual expenditure for financial support of territorial programs provided reflected in the formula (2), which can be represented as follows:

$$\begin{cases} T \cong F, \\ N_1 \leq N_2, \end{cases} \quad (3)$$

where T is the need for financial support regional program;

F is the actual cost of financing the territorial program;

N_1 is federal per capita quota of financing;

N_2 is territorial per capita quota of financing;

Imbalanced territorial program is expressed by its financing deficit (D):

$$D = T - F, \quad (4)$$

where T is the need for financial support regional program;

F is the actual cost of financing the territorial program;

The program will be deficient if it is approved in the value calculated on the basis of per capita funding understated standards, i.e. when territorial standard lower than the standard, approved the state guarantee:

$$\begin{cases} D > 0, \\ N_1 \geq N_2, \end{cases} \qquad (5)$$

where D is the funding gap of territorial program;

N_1 is federal per capita quota of financing;

N_2 is territorial per capita quota of financing;

The total amount of underfunding of state-guaranteed free medical care in the Russian Federation will be determined as the sum of deficits of financial security of all regional programs of state guarantees (G):

$$G = \sum D, \qquad (6)$$

where $\sum D$ is the amount of deficit of financing of regional programs in all regions of the Russian Federation.

The total demand of the population for health care can be represented as the sum of expenditures of the federal budget, the actual cost of financing regional programs of free medical care, benefits under voluntary health insurance, as well as funds received medical organizations from providing paid medical services (M):

$$M = A + F + I + P, \qquad (7)$$

where A is the cost of the federal budget;

F is the amount of the actual cost of funding of regional programs;

I is payments under agreements of voluntary medical insurance,

P is money obtained by the medical organizations for providing paid medical services

2.4 Method of observational generalization and logical inference

Currently, underfinancing of the territorial programs is offset by the population independently by referring to the sphere of voluntary health insurance and paid medical services. When adjusting state obligations shall take into account the presence of the deficit of financial support regional programs of state guarantees has actually redistributed due to its insecurity, but without legislative consolidation.

Reserve reallocation will be the increase in payments under voluntary health insurance funds received medical organizations from providing paid medical services. Particular attention shall be paid to the growth potential of the market for voluntary health insurance and paid medical services. This will determine the growth potential to the redistribution of financial commitments in the health of the Russian Federation as a whole and in the system of mandatory health insurance in particular.

The volume of government obligations, available redistribution expressed for the resources can be defined as (H):

$$\begin{cases} H = G + I_t + P_t, \\ G \leq I + P, \\ I_t + P_t \geq 0, \end{cases} \qquad (8)$$

where G is the total underfunding of state-guaranteed free medical care;

I_t is increase in payments in the system of voluntary health insurance (in absolute terms);

P_t is growth of volume of money obtained by the medical organizations for providing paid medical services (in absolute expression);

I is payments under agreements of voluntary medical insurance,

P is money obtained by the medical organizations for providing paid medical services

If the total underfunding of state-guaranteed free medical care exceeds the amount of payments under contracts of voluntary health insurance funds received medical organizations from providing paid medical services, the amount of state obligations, available redistribution, will be reduced by the amount of the excess.

Condition of development is the growth sector of voluntary health insurance and paid medical services. At that, more preferred is voluntary health insurance:

$$\begin{cases} I_t \to \infty, \\ P_t \to \infty, \\ I_t \geq P_t, \end{cases} \qquad (9)$$

where I_t is increase in pay offs in the system of voluntary health insurance (in absolute terms);

P_t is growth of volume of money obtained by the medical organizations for providing paid medical services (in

absolute terms).

Based on the considered indices, it is possible to determine the coefficient of redistribution, which will reflect the share of government obligations in terms of money available in the redistribution of private health sector, i.e. as far as possible to revise the per capita quota of financing of health care in the direction of reducing it. Redistribution factor (K):

$$K = \frac{H}{M}, \qquad (10)$$

where H is the amount of government liabilities, available redistribution;
M is the population's need for medical services.

The average coefficient of redistribution will be calculated as the arithmetic mean ($\overline{K}$):

$$\overline{K} = \frac{\sum_{1}^{x} K}{x}, \qquad (11)$$

where $\sum_{1}^{x} K$ is the sum of the redistribution factors of x periods;
x is the number of periods.
Characteristics of the indicators used in the calculation are presented in Table 1.

Table 1 - Characteristics of the indicators used in the calculation of the redistribution factor of financial liabilities

S/N	Design-ation	Indices	Calculation method
1	A	Funds of the federal budget of the Russian Federation allocated for the financing of health care	
2	B	Funds of the consolidated budget of the Russian Federation subject allocated for the financing of health care	
3	C	Funds of the mandatory health insurance system, used to finance health care	
4	T	The need for financial support of the territorial program of state guarantees of free medical care, bln RUR	$T = A + B + C$
5	F	The actual cost of financing the territorial programs, bln RUR	
6	N_1	Federal per capita quota of health care financing	
7	N_2	Territorial per capita quota of health care financing	
8	D	Deficit of financing of territorial programs, bln RUR	$D = T - F$ Balance condition: $\begin{cases} T \cong F \\ N_1 \leq N_2 \end{cases}$
9	G	Overall amount of underfinancing for the state-guaranteed free medical aid, bln RUR	$G = \sum D$
10	I	Payments under agreements of voluntary medical insurance, bln RUR	
11	I_t	Growth of pay offs in the system of voluntary medical insurance, bln RUR	$I_t = I_x - I_{x-1}$
12	P	Money obtained by the medical organizations for providing paid medical services, bln RUR	
13	P_t	Growth of volume of money obtained by the medical organizations for providing paid medical services, bln RUR	$P_t = P_x - P_{x-1}$ Condition for development: $\begin{cases} I_t \to \infty \\ P_t \to \infty \\ I_t \geq P_t \end{cases}$
14	M	Population's need for health services, bln RUR	$M = A + F + I + P$
15	H	The volume of government obligations, available redistribution, bln RUR	$\begin{cases} H = G + I_t + P_t \\ G \leq I + P \\ I_t + P_t \geq 0 \end{cases}$ at $G > I + P$, $H = (G + I_t + P_t) - (G - I - P)$
16	K	Redistribution factor	$K = \frac{H}{M}$

3. Results

Initial data for the calculation of the redistribution of financial liabilities is presented in Table 2. When calculating, the

population's need for health care services is considered without the federal budget allocated to policy and program direction in health care, other than funding for the program of state guarantees. Redistribution is planned to produce as part of public funds allocated to the financing of health services provided under the program of state guarantees, and private funds coming into the health care system through voluntary health insurance and paid medical services.

Table 2 - Initial data for the calculation of the redistribution of financial commitments in health, billion RUR.

Year	The amount of actual expenditures for financing territorial programs (F)	Overall amount of underfinancing for the state-guaranteed free medical aid (D)	Payments under agreements of voluntary medical insurance (I)	Money obtained by the medical organizations for providing paid medical services (P)
2009	1378.60	384.60	64.49	221.00
2010	1449.90	337.30	65.27	252.00
2011	1596.90	238.00	73.58	288.00
2012	1718.40	164.50	82.00	332.00
2013	1976.40	81.70	89.94	358.00

Data is presented based on actual indicators of financing regional programs of state guarantees, the total deficit financing these programs, as well as the amount of funds of voluntary health insurance and paid medical services.

Based on available indicators, the maximum, minimum, and average values of changes in the actual performance are calculated. According to these values, 81 scenarios were formed, reflecting all possible combinations of variations of actual expenditures in the coming year. Table 3 shows the calculation of the coefficient of the redistribution of financial commitments to public health care between public and private funding sources for health data for 2009-2013, excluding the generated script.

Table 3 - The calculation of the coefficient of the redistribution of financial commitments to public health care between public and private funding sources for health data for 2009-2013, bln RUR

Year	T	F	G	M	I	I_t	P	P_t	H	K
2009	1763.20	1378.60	384.60	1664.09	64.49	-	221.00	-	285.49	0.172
2010	1787.20	1449.90	337.30	1767.17	65.27	0.78	252.00	31.00	349.05	0.198
2011	1834.90	1596.90	238.00	1958.48	73.58	8.31	288.00	36.00	282.31	0.144
2012	1882.90	1718.40	164.50	2132.4	82.00	8.42	332.00	44.00	216.92	0.102
2013	2058.10	1976.40	81.70	2424.34	89.94	7.94	358.00	26.00	115.64	0.048

Each scenario has redistribution factor calculated, and the average coefficients based on the data of Table 3. The result of the calculations is the following values of the coefficient of redistribution obtained: minimum - 0.115, maximum - 0.119, average - 0.117. Capitation financial support program of state guarantees of free provision of citizens of the Russian Federation on health care in 2015 is set at 12,096.70 RUR, in 2016 - 12,642.10 RUR.

By using the obtained coefficients, the standard is as follows:

for 2015

12,096.70 - (12,096.70 × 0.115) = 10,705.58 RUR.

12,096.70 - (12,096.70 × 0.117) = 10,680.64 RUR.

12,096.70 - (12,096.70 × 0.119) = 10,657.19 RUR.

for 2016

12,642.10 - (12,642.10 × 0.115) = 11,188.26 RUR.

12,642.10 - (12,642.10 × 0.117) = 11,162.19 RUR.

12,642.10 - (12,642.10 × 0.119) = 11,137.69 RUR.

Fulfilment of the condition of providing for the growth of co-financing health care from private sources (voluntary health insurance and paid medical services) will provide an opportunity to review the rate of redistribution. Lower limits for the coefficient is the minimum of the calculated values, and the top - the maximum, followed by a change in the direction of increasing, thus taking into account the economic opportunities to maintain a balance of state guarantees of medical care.

Market conditions require an evaluation of the real possibility of state involvement in the financing of national health. Needs of the population in health care shall be provided with financial resources, regardless of the source of these resources. State program of the Russian Federation among the priorities of public health policy are fixed: creation and

development of competitive markets, the development of public-private partnership, the gradual de-monopolization of the state health care system, which confirms the conclusions of the authors.

4. Discussion

According to the level of funding for the National Health, Russian Federation, according to the World Health Organization, refers to the group of countries with non-priority type of health care, in contrast to other developed countries. Despite the fact that total expenditure increases every year, the share of consolidated public expenditure on health in the gross domestic product of the Russian Federation hovers around 3.5%, while the average for European countries is 8% (Figure 4).
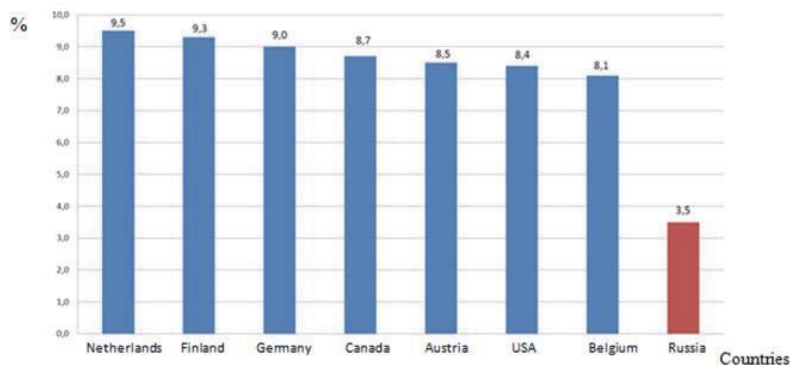
Figure 4 - The share of consolidated public expenditure on health in GDP, %

As it can be seen from the data, the rate of the Russian Federation is more than 2 times lower than the European average, which indicates the presence of the financial problems the functioning of health care. Indicators of natural growth, morbidity, life expectancy of the Russian population are considerably below that demonstrated by the European countries, underscoring the correlation between spending on health and the health of citizens.

The Russian Federation is currently funding the health care system is based on the use of models of Beveridge and Bismarck, which is implemented in the coexistence of mandatory health insurance system and paternalistic orientation of public spending on health care in the country.

The main problem of implementation of the program of state guarantees of free medical care is a significant deficit in its financial support (Table 4). Despite the existence of positive trends, such as the annual increase in the actual cost of the program, reducing the deficit of the financial support for regional programs, increase the number of subjects in which the program non-deficit, the deficit persists (more than 20% in certain territorial programs). This fact directly indicates that the alleged guarantee of free medical care is not implemented; the available resources are insufficient to ensure the financial regulatory requirements.

Table 4 - Dynamics of financing regional programs of state guarantees of free provision of medical care to citizens in the Russian Federation in 2009-2013, bln. RUR.

Index	2009	2010	2011	2012	2013
Actual expenditure from all sources of financial support	1378.6	1449.9	1596.9	1718.4	1976.4
Growth, %	-	5.2	10.1	7.6	15.0
% from GDP	3.5	3.2	2.9	2.7	3.0
Including: Federal budget	391.6	393.1	403.7	411.4	330.3
Share, %	28.4	27.1	25.3	23.9	16.7
Budgets of subjects	481.6	516.4	568.3	580.6	478.2
Share, %	34.9	35.6	35.6	33.8	24.2
Compulsory health insurance system	505.4	540.4	624.9	726.4	1,167.9
Share, %	36.7	37.3	39.1	42.3	59.1
Lack of financial support for regional programs	384.60	337.3	238.0	164.5	81.7
The number of subjects of the Russian Federation, in which the territorial programs of state guarantees are sufficient	8	9	11	17	25

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The public health system is based on principles such as free, accessible, and universal coverage. At the heart of financial security, there are standards for the volumes of care, standards of financial security of these volumes, and per capita financing standards of assistance provided under the regional programs of state guarantees of free medical care to the population. The state guarantees the minimum standards for all those in need of medical care that is provided to citizens free of charge in state and municipal health facilities.

The current health care system is contrary to requirements needs of the population with the opportunity to pay for medical services provided by private clinics with a high level of service, no queues, and long waiting times, highly qualified staff using the latest equipment. Only 6% of private medical organizations are involved in public health insurance system, which is due to low tariffs to pay for health care provided to the population free of charge.

Immediate payment after providing services is a common method of payment, but there is a better option for the patient - the purchase of medical insurance policy. The peculiarity is in the presence of a risk component, which allows avoiding large expenditures for treatment, which would be impossible to produce in full upon receipt of paid medical services in the classical representation without a contract of voluntary health insurance. After the payment of insurance premiums, the insured person gets the right to health care according to the chosen insurance program, which will be no longer paid by the patient, but by the insurance company with which the contract was drawn.

Voluntary health insurance in varying degrees is carried out in many developed countries. Figure 5 shows the structure of expenditures on health care in the Russian Federation, Germany, France, and the United States. One of the features of foreign practice is complementary operation of the compulsory and voluntary health insurance.
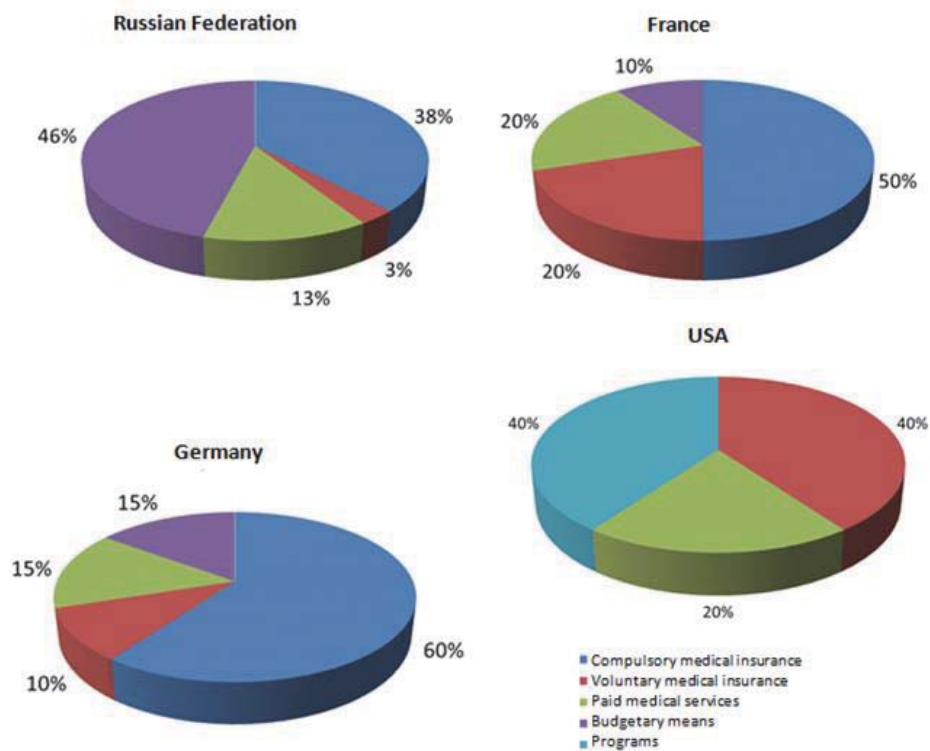

Figure 5 - Structure of expenditures on health care

The market for voluntary health insurance of the Russian Federation has the potential development, which is currently not implemented. Promising for the national health system is to undertake an integrated model of health insurance that combines its obligatory and voluntary forms. However, special attention shall be given the issue of access to health care. It is obvious that the poorer sections of the population form the demand for health care goods and services provided for free, more affluent sections of the population and have the opportunity to choose to use health services provided by a fee, without queues (i.e., dosing is excluded in this way), and with a higher level service, but due to the payment of the established price.

One explanation for the existence of public health, along with the market failure (imperfect competition, asymmetric

information and externalities), can be regarded as the assertion that the availability of medical services should not be dependent on the solvency of the population.

There is a controversial opinion among economists as to whether perceived health services as a special commodity. Representatives of egalitarianism believe that services must be equally accessible regardless of income level consumers. According to the opposite point of view, the effect of the level of health expenditures on human life is not so simple. Often, bad habits, nutrition, education, have a more serious impact on the health status and life expectancy. Therefore, medical care shall not be treated differently than other commodities.

Position when government intervention in the economy is necessary, because it is best known for the interests of people, even if they themselves do not understand them and do not realize, is called paternalism. This provision has spread especially in relation to health and education, justifying the relevance of the existence of the public sector in the interests of each individual and society as a whole.

5. Conclusion

This debate sharpens an important for the health system question - a question of justice. The content of justice may have two fundamental principles allocated: the principle of equivalence/solidarity and the principle of ability to pay. The two kinds of justice are formed based on these principles: horizontal and vertical. Horizontal equity implies that all people equally seeking medical care receive it in an equal volume, regardless of their financial capabilities. Vertical equity implies that the access and quality of services they receive shall be based not only on medical indications, but also on the financial capacity of consumers.

The ratio of efficiency and equity is characterized by an inverse relationship, i.e., to enhance economic efficiency, part of justice shall be given up, and vice versa. In this discussion, several questions arise. Firstly, as far as possible it is necessary to give up equity to increase economic efficiency in the public health sector, and vice versa.

Secondly, if a decision is made on improving justice, whether such improvements will be Pareto efficient. For example, if there will be an increase in the volume of free medical care from public funding sources is the movement from a point below the production possibility curve (inefficient), to a point lying on the curve, or it will be only the movement along the curve when increasing costs health care, the state will be forced to cut costs in other areas?

And thirdly, the extent of the positive effect of improving fairness, i.e. by increasing the volume of care provided free of charge, if such be the case, exceed the level of losses from lower economic efficiency?

If we focus on the provision of health equity, the change in income distribution will be one of the activities of the state. For example, it is possible to use a progressive tax system, while the poor and the rich will be equalized to some extent. However, the health care system will be more acceptable is the approach based on the increase in the volume of medical services offered to the public free of charge. There is no doubt that by increasing the amount of health care, the state improves the position of the poorer sections of the population who cannot afford the services of private medical services market because of lower income, i.e., increases the level of justice. Moreover, as long as there is an improvement for the position of the poor relative to the rich, the principle of justice will be respected.

If we consider the principle of ensuring efficiency in the public health sector, and do not touch the problem of justice, then no increase in free medical care can be considered acceptable if it leads to economic losses. These losses can be expressed, for example, the need to reallocate resources from other areas of use in the sector of providing free health care in resource-limited settings, which leads to economic (imputed) costs.

Thus, it becomes necessary to determine the amount of care provided to the public free of charge, from the budget and mandatory health insurance system that will meet the principle of fairness and to ensure cost-effectiveness as the national health and public sector as a whole.

The questions and identified issues of the health financing, considered by the authors, allow for the conclusion of the existence of possibility and necessity of the implementation of financial innovation in the field of health insurance through reallocation of responsibilities between public and private funding sources.

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