

Social Health Insurance Reforms—Mid-Term Experiences of Poland and Russia

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As a result of transition process to market economy, Poland and Russia have come a long way from a centrally planned budget for social security to an insurance-type model in the social sphere. After more than two decades of reforms, it seems essential to compare and evaluate the policy solutions introduced in terms of the reform goals achieved and exposure to current challenges. The paper presents an analysis and comparison of social health insurance reforms conducted in Poland and Russia since the beginning of the 1990s. Moreover, the current problems of and future challenges for health care financing systems are identified. The varied experiences of Poland and Russia over more than 20 years show mid-term lessons which could be useful to other countries, especially those that face socio-economic transformation, in their choice of strategy and the practice of similar reforms.

Keywords: social health insurance, health care reforms, Poland, Russia

The formation of a new model of health care financing began in Poland and in Russia at the beginning of the 1990s as a continuation of the introduction of market economies due to a change in political course. At that time, Poland and Russia were among the more developed of their political partners: Poland in the Central and Eastern European (CEE) region and Russia among the states of the former Soviet Union. They also started their economic reforms at the same time, including: the liberalization of prices, the privatization of state property, and changing of the social sphere. They also had a common past of social security based on state support, budget financing, and a universal approach to social services. It is important to mention that they were among the first states to start their health care reforms in the transition period. However, the selection of these two countries for a mutual study was determined not only by these uniting factors, but also their unique social transition paths and differences in social health insurance reforms. These common and distinctive backgrounds are able to provide meaningful lessons and interesting recommendations for others.

In the scientific literature, issues of social insurance reforms in transition and developing countries have

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been considered broadly from both theoretical and practical points of view. For example, Antia and Lanzara (2011) discussed the Chilean, Uruguayan, and Brazilian systems; Brodmann, Jilloson, and Hassan (2014) described changes in social insurance in Jordan, while Gusmano, Rodwin, Weisz, and Ayoub (2016), Marten et al. (2014), and Rodwin (2015) compared social and health insurance reforms in Brazil, Russia, India, China, and South Africa (BRICS). Health care reforms in Poland and other CEE states have been examined by a long list of researchers (e.g. Golinowska, Sowa, & Topór-Mądry, 2006; Wagstaff & Moreno-Serra, 2009; Nemeč, Cankar, Kostadinova, Maly, & Darmopilova, 2013). In addition, the features and peculiarities of health insurance reforms in Russia have frequently been discussed in the context of their challenges and outcomes (e.g. Grishchenko, 2007; Cook, 2015) as well as economic, social, demographic, and other aspects (Tompson, 2007; Rechel & McKee, 2009; Kutzin, Jakab, & Cashin, 2010; Marten et al., 2014). In contrast, the mid-term experience of Poland and Russia after more than two decades of substantial health insurance reforms has been examined to a very little extent in the scientific literature. The purpose of this paper is to provide an overview, comparison, and evaluation of the social health insurance reforms conducted in Poland and Russia in terms of the achieved goals and exposure to current and future challenges.

The remainder of the paper consists of three main parts. Firstly, an overview of health insurance reforms conducted in Russia is presented. Secondly, the main lessons from the Polish social health insurance reforms are considered. Finally, a comparison of the results of the Polish and Russian means of reform in their social health insurance schemes is discussed.

Health Insurance Reform in the Russian Federation

The countries of the former Soviet bloc have chosen various financial and management approaches to health care, including universal, insurance-based, or mixed systems. Russia was the first country in the post-Soviet territory to introduce a model of compulsory medical insurance in 1993. The insurance model replaced the Semashko model and it was introduced based on the positive experience of developed countries, providing solutions in terms of various issues, such as the development of competition between health care organizations, the reduction of costs by minimizing medical expenditures and the optimization of care for citizens, the protection of the interests of insured persons in medical policy, and legislation on the contractual basis for the insurance company and the patient. Among the approaches proposed were the following: the creation and activity of medical insurance companies; changes to financing by reducing the number of bed-days of hospital care, the intensification of ambulatory care, and extension of practice of family doctors; increases in the wages of health workers, etc.

What barriers influenced the success of the health insurance model? First of all, the insurance model is effective in countries with an average and higher density of population, allowing the application of market principles in the work of clinics, competition between clinics for patients, the stimulation of an effective allocation of financial resources, and the introduction of innovations in medical practice. Countries with effective insurance models of health care financing are characterized by higher levels of territorial development, with the following indicators: high population density, uniformity of settlement, developed transport networks in good conditions all year round, and a high proportion of cities with developed medical infrastructure. In contrast, Russia has a significant amount of territories with an average or low density of population, which nevertheless requires medical security for all citizens, even in very distant regions. A real choice of clinic or doctor is also difficult due to their limited presence in rural territories. Even in the European part of the country,

the distance between cities is 40-50 km; in the east, it is 300-500 km or more, with insufficient transport accessibility and a poor state of roads.

Examining indicators based on Russian features argues the impact of territorial factors on the realization of health care services. In 2014, the number of hospitals in Russia was 9.1 per 1,000 people, almost double the OECD average of 4.8 (OECD, 2015). However, from 1990, there was a more than twofold depletion in the number of hospitals and clinics in rural territories in Russia; the number of hospitals in cities dropped to a lesser extent, whereas the number of clinics increased. These tendencies remain the same when comparing the relative indicators, for instance the distributions of hospitals and clinics per 100,000 of the population regionally. As a result, an inequality in access to health care in terms of territorial factors is observed. Rural populations have less access to health care services and poorer overall health than urban populations (Cook, 2015). Along with rural-urban differences within regions, there are also two distinct dimensions of inequality that affect access to health care in Russia, at the household level and at the regional level. There is also a lack of competition between medical insurance companies, which have to provide a choice of health care clinics and the protection of the rights of patients. The gap between the need to optimize health care expenditures (as a market principle) and ensure the availability of health care assistance throughout the whole territory (at least in territories with equal populations as the social responsibility of the state) is a crucial issue in the framework of the insurance model.

The second issue is that according to legislation in Russia, all citizens have access to free medical assistance, independent of their place of stay. In reality, it is very difficult to receive free medical services in various territories or regions. The insurance model presupposed competition between clinics and hospitals for patients; however, it is difficult to implement this under the conditions of the attachment of citizens to nearby clinics.

The next issue is related to the participation of patients in health care financing. In place of the official position of free universal health care coverage, there are out-of-pocket payments or payments made directly to health care centres, which exhibit a growing trend (see Figure 1).

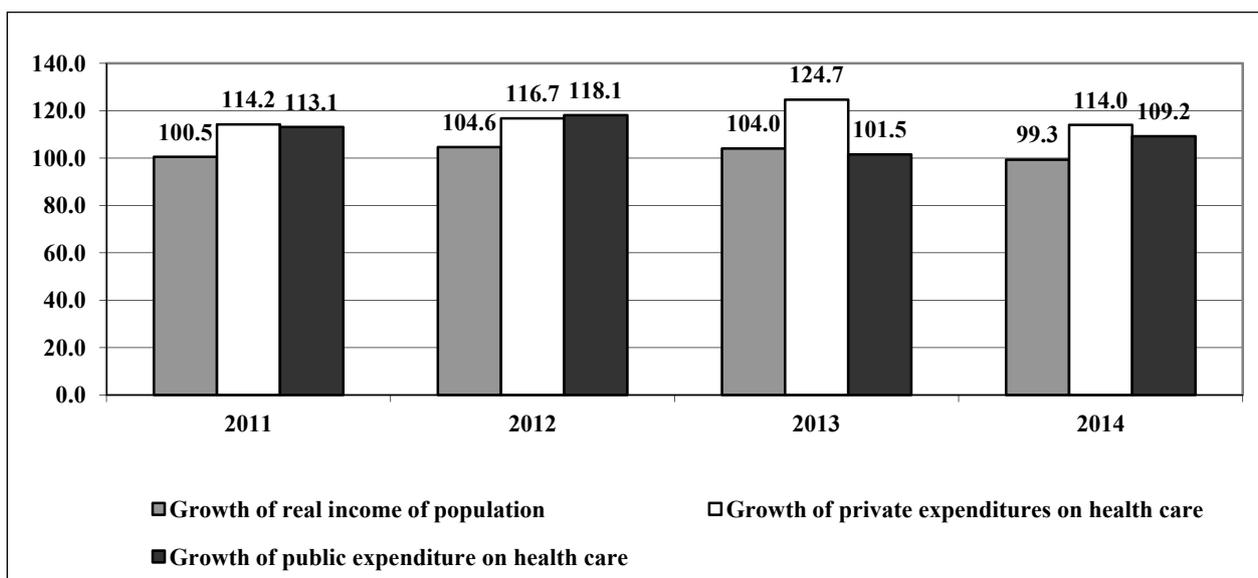


Figure 1. Growth of public and private expenditure on health care in comparison with the real income of the population in Russia, 2011-2014. Source: Authors' own calculations.

The public sector as the main source of health care expenditure shows steady growth of 10% on average; however, with the current inflation rate of 7.5% and 3.6% of GDP, it has provided stable but insufficient financing in the last four years. In 2013, the share of health care expenditure was much lower than the average of 9% in OECD countries (OECD, 2015). Despite the intention to shift to an insurance-based system, federal and regional budgets still administer about 60% of public health care expenditure. The remainder goes through compulsory medical insurance, which was initially financed chiefly via dedicated employers' contributions to regional medical insurance funds, a system that led to considerable differences in the level of compulsory medical insurance income across regions and failed to generate sufficient revenues to finance the system's commitments (Tompson, 2007).

Comparative regional studies indicate that residents of poorer, less-developed regions spend higher shares of their income on health care than those living in wealthier regions. Residents of poorer regions pay because no free specialists or diagnostic equipment are available, while those residents of wealthier regions typically pay to obtain higher quality care. Finally, health outcomes differ starkly across regions (Tompson, 2007).

The largest share of household spending on health care is devoted to pharmaceuticals and the gap between commitments and resources is particularly stark when it comes to financing pharmaceuticals provision. The reliance on formal and informal cost sharing with respect to pharmaceuticals provision underlies the unusually large household share in total health care expenditure in Russia as pharmaceuticals themselves account for an exceptionally large share of Russian health expenditure.

The introduction and promotion of the compulsory medical insurance model in Russia has encountered real obstacles, among them: its huge territory with different regions, disparities in the development of cities and rural territories, and low levels of population income (especially in rural territories). In many respects, the medical insurance model does not coincide with geographical, economic, and social conditions of this country. Today, Russia has a mixed centralized and insurance-based model due to its country features. Most recommendations for improving the efficiency of the health care system in Russia are focused on the technical aspects of reform, proposing changes in organization, management, and financing.

Transition of the Health Care Financing System in Poland

In Poland, the most important reasons for introducing changes in the health care financing system were the following: demographic trends (ageing population as a result of increasing life expectancy, declining fertility rate, and migration flows) and the risk of instability in public finance.

In Poland, extensive reform efforts have taken place since the start of political and economic transformation in 1989, including the first systemic changes to the health care financing system. The concept of "pure" social health insurance provided the ideological basis for changes to the structure of the system, but in practice, various derogations from the Bismarck insurance model were applied in favour of budget funding solutions. Consequently, the current health care system is neither a typical insurance scheme nor a "pure" tax-funded system.

With the beginning of 1999, the strongly centralized health system, based on the Semashko model, was replaced with a decentralized system of mandatory social health insurance, complemented with financing from state and territorial self-government budgets. One of the most important rules introduced in 1999 was the transparent separation between health care financing and provision. Since then, the role of third-party payer has been played by decentralized public institutions—regional health insurance funds. In 2003, they were

centralized and joined within the National Health Fund (NHF)—which is currently the sole payer in the system in charge of health care financing and contracts with public and non-public health care providers. Moreover, at the same time, changes were introduced to transform the existing public health care providers, usually operating in the form of budgetary units, into independent institutions providing publicly financed health care services. The solutions introduced were partially based on the Bismarck model, but they also contained specific rules very different from this model, such as the absence of competition among health insurance funds, the specific structure of health insurance contributions, and the lack of financial participation of the employer in this contribution.

Similar to Russia, health insurance contributions in Poland take the form of a withholding tax, which is entirely borne by the employee. The state budget covers contributions for vulnerable groups. Up to 86% of contributions paid in a given year can be deducted directly from tax contributions. Compulsory health insurance covers almost 98% of the population and guarantees access to a broad range of health services. The NHF is the sole payer in the system and there is no possibility of opting out. Positive reimbursement lists have been in place since the end of 2009 and are issued periodically by the Ministry of Health. The limited financial resources of the NHF mean that the broad entitlements guaranteed on paper are not always available; in practice, there are many difficulties with access to specialized health care. In terms of cost sharing, this is limited, with the exception of medicines, medicinal products and auxiliary medical devices, health resort treatments, and certain dental procedures and materials (Sagan et al., 2011).

Health care in Poland is funded from both public and private sources, with a prevalent share of the former in the form of contributions to compulsory social health insurance. Public funds cover about 70% of total health care expenses and the rest of expenditure is financed mainly through out-of-pocket payments. Out-of-pocket payments contain all costs paid directly by the consumer, including direct payment for health care services, formal cost sharing, and informal payments (for more see Borda, 2008). Public sources are unable to cover all health care expenses and therefore the use of additional private sources is necessary. Consequently, one can observe an increasing participation of individuals in health care financing, more in the form of out-of-pocket payments than in the form of voluntary private health insurance. In 2013, as much as 75% of private health care expenses in Poland comprised out-of-pocket household expenses. Despite the theoretically wide scope of health services provided by the public system, a significant percentage of Polish households use privately funded medical services, which are out-of-pocket financed. Direct expenses for health care, in contrast to premiums paid for health insurance, often constitute a sudden burden on household budgets, which is especially significant in the case of pensioners, families with many children, and people with relatively low incomes.

In Poland, private health insurance (PHI) does not play a significant role in health care financing. The role of PHI is to supplement the public health care system. By purchasing a private insurance policy, it is possible to gain quick access to health services otherwise characterized by long waiting lists in the public system, as well as to use high-quality services provided by private hospitals and medical centres. However, the lack of appropriate tax incentives, relatively high premiums, and competition from private medical services providers (in the form of medical subscriptions) limit the development of the PHI sector.

Taking into account its modest financial, human, and material health care resources and the corresponding outcomes, the overall financial efficiency of the Polish health care system is evaluated as satisfactory (Sagan et al., 2011). The main challenges facing the system seem to be the following: increasing demand for health care and long-term care services provided to senior citizens due to the ageing population trend, further initiatives to

commercialize hospitals, achieving the accessibility and good quality of health care services and improving patient satisfaction within the system.

Results and Discussion

In summary, both examined countries have moved a long way in the transition from their previous centralized and state-financed health care schemes to the present mixed systems. The main similarities and differences in the functioning of social health insurance systems in Poland and Russia are presented in Table 1.

Table 1

Comparison of the Social Health Insurance Systems of Poland and Russia on the Basis of Selected Criteria

Criteria	Poland	Russia
Year of reform implementation	1999	1993
Coverage (target group)	Whole population	Whole population
Enrolment (compulsory, voluntary)	Compulsory	Compulsory
Administration (public institutions centralized or decentralized)	Public, centralized—National Health Fund as a third-party payer	Public, centralized—Federal Fund of Compulsory Medical Insurance as a third-party payer
Contributions	Income-dependent contribution, rate of 9%	Income-dependent contribution, rate of 5.1%
Contributor(s)—who pays (employer and/or employee)	7.75% deducted directly from income tax, 1.25% financed directly by employee	5.1% financed directly by employer
Service areas financed by the system	Broad range of services included in positive reimbursement list (since 2009)	Broad range of services
Coverage of population (in %)	About 98%	About 100%
Cost sharing (if any)	Limited to purchase of medicines, medical products and auxiliary medical devices, certain dental procedures and materials, health resort treatments	Limited to purchase of pharmaceuticals, high-tech medical services, certain dental procedures and materials, health resort treatments
Type of private health insurance (supplementary, complementary, substitutive)	Supplementary to the services provided by the public system with long waiting lists and/or those of low quality	Supplementary to the services provided by the public system with long waiting lists and/or those of low quality
Tax incentives for private health insurance	None	Private health insurance premiums (maximum RUB 120,000 in a year) can be deducted from taxable income
Current main problems	Increasing demand for health care and LTC services provided to senior citizens; further initiatives to commercialize hospitals, achieving accessibility and good quality of health care services	Insufficient health care indicators for population; further optimization of the number of bed-days during hospital care and intensification of ambulatory care; increase in wages of health workers

Note. Source: Authors' own study.

When analyzing the social health insurance schemes in Poland and Russia, many similarities can be observed. Both countries decided to implement compulsory social health insurance with income-dependent contributions administered by a separate public institution (third-party payer). It is also important to mention the differences in the amount of contributions (higher in Poland) and the source of financing (employee or employer). Both systems provide almost universal coverage addressed at the whole population and financing a very wide range of health care services (at least theoretically). In the case of the Russian Federation, an advantage can be seen in the implementation of tax deductions for private health insurance premiums—a factor

that can stimulate the development of this insurance sector. In Poland, such solutions are as yet missing. Both countries are facing problems with their health care systems: in Poland, these problems are mostly related to the ageing population trend, as well as the need to improve the quality of health care services; in Russia, the main challenges concern the significant regional disparities in health care organization and provision, as well as the lack of sufficient health care indicators for the population.

In order to evaluate the implemented reforms and the current shape of health care financing systems in Poland and Russia, some general conclusions can be drawn when analyzing changes in the level and structure of health care expenditure in the period 1995-2014 (see Table 2).

Table 2
Health care Financing in Poland and Russia—Selected Ratios

Characteristics		Years				
		1995	2000	2005	2010	2014
Total health care expenditure as % of GDP	PL	5.5	5.5	6.2	7.0	6.7* (2015)
	RU	2.2	2.9	n.a.	5.8	5.8 (2013)
Total health care expenditure per capita (USD PPP)	PL	409.0	583.5	856.6	1,394.9	1,676.7* (2015)
	RU (WHO estimates)	301.11	370.56	615.74	1,397.18	1,835.71
Private expenses as % of total health care expenses	PL	27.11	29.97	30.6	28.26	29.02
	RU	26.12	40.12	38.02	45.88	47.8
Household out-of-pocket expenses as % of total health care expenses	PL	27.11	29.97	26.12	22.11	23.46
	RU	16.89	29.97	31.32	43.3	45.85

Notes. PPP = purchase power parity; n.a. = not available. Other sources of health care financing, such as international funds, are not included. Source: WHO European Health for All Database, * OECD Health Data.

As presented in Table 2, the level and structure of health care financing have undergone substantial changes since 1995. In Poland, the share of GDP allocated to health has remained at a relatively stable but still low level. In Russia, the share of health expenditure in GDP is lower compared to Poland; however, the dynamics of this ratio during the period analyzed are much stronger. In both countries, the amount of total health expenditure per capita has increased (in Poland from USD 409 PPP in 1995 to USD 1,676.7 PPP in 2015 and in Russia from USD 301.11 PPP in 1995 to USD 1,835.71 PPP in 2014), but the level of spending has remained relatively low. This is related not only to the level of economic development, but also the relatively low share of health spending in GDP, which indicates low preferences for health care needs in the distribution of domestic product. As mentioned above, in the case of Russia, there are significant regional disparities in the amount of health care expenses per capita. In Poland, private expenditure on health care represents nearly 30% of total health care expenditure, while in Russia, especially in 2010 and 2014, this ratio reached the level of 46%-48% with significantly increasing participation of households in health care financing.

Conclusions

The health care system is a key factor in the social well-being of the population of a country. At present, various health care models and their modifications are used around the world. Each of these models has its own characteristics; however, they also have to coincide in terms of the initial conditions of their realization, taking into account the political, economic, and social situation, as well as the geographical, cultural, and historical surroundings.

In the process of reforms of the Polish and Russian health insurance systems, the attention should be focused on several issues. First, it is clear that the main factor influencing the effectiveness of reforms is the degree of consistency and comprehensiveness, namely in the pursuit of the original principles of reforms and their implementation, in conjunction with other objectives of the medical and insurance sectors. Second, there should be compliance with insurance principles in the organization and management of health insurance funds. Insurance is needed, but governments should not substitute insurance measures for tax in terms of social security principles. It is important to strive for a clear definition of the circle of payers of insurance funds and the number of recipients; these are currently not the same and the funds sometimes perform the functions of state social security. Third, there needs to be monitoring of the progress of social reforms, ensuring compliance with the interests of insured persons and guaranteeing minimum social standards, while encouraging the development of competition between the actors in the field of social health insurance.

The varied experiences of Poland and Russia over a period of more than 20 years provide mid-term lessons that could be useful to other countries, especially those facing socio-economic transformations in terms of their choice of strategy and the practice of similar reforms. The study results suggest, among others, that a relatively low level of total expenditure on health care and the inefficient allocation of financial resources in health care sector seem to be common problematic features in both examined countries.

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