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Health Care Reform in Russia and the United States

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I. Introduction

Article 25 of the Universal Declaration of Human Rights specifies that everyone has a right to adequate medical care. Yet what constitutes adequate medical care and how to deliver it is a problem states across the world confront. While basic measures to assess health care delivery systems include cost (both individual and societal), coverage, quality and outcome, all systems face problems in securing these objectives.

Health care systems across the world face similar problems of rising costs, access, quality of service, and technological development. The growing and aging of populations will increasingly tax health care delivery systems with additional burdens. Governments across the world are challenged in how to address the health care needs of its people, demonstrating that there is no ideal system.

This article compares health care reform in the United States and the Russian Federation since 1990. Both countries have undertaken a variety of reforms in the last 25 years aimed at improving health care delivery in their countries. For the United States, it is an effort to reform a mainly private health care insurance and delivery system with some aspects operated by the government or NGOs. With Russia, it is the rebuilding of a health care system after the collapse of the state-run one under the Soviet Union. Despite these differences, comparisons of the two countries yield interesting parallels, convergences, and lessons. This article will undertake its comparison by looking at costs and access to medical service because these factors can be easier to correct by economic and political reforms taking place in both countries. The aim is to

ascertain if countries with so different historical backgrounds and economical and political structure share experiences in providing health care for its citizens.

II. United States

The key to understanding health care policy and reform in the United States since 1990 resides in knowing two facts. First, there is no such thing as a single health care policy or system in America; it is a decentralized and fragmented delivery system that involves a variety of public, private, non-profit (NGO) players operating in an environment that crosses several layers of government. Second, health care in the United States is neither a constitutional nor a legal right. Health care is provided between two basic delivery systems–a private, market driven for profit system based on the ability to pay, and a second one offered by the government to individuals free or at reduced cost who meet specific statutory requirements.

These two facts are significant because they explain not only the history of health care policy in the United States but they also set the context for recent American reforms. Specifically, in 2010 the United States Congress adopted the Patient Protection and Affordable Care Act (Affordable Care Act or "ACA"), more commonly referred to as Obamacare. The ACA was proposed by President Barack Obama while running for president and it was passed with a near straight party-line vote of Democrats in the US House and Senate in 2010. Obamacare is controversial, with most individuals and those who identify as Democrats support it, Republicans opposing it. Since its adoption in 2010 there have many efforts by those opposed to it to repeal the ACA, along with efforts to challenge its constitutionality in court or otherwise to block its implementation.

A. The Context of Recent US Health Care Reform

When World War II ended, the structure of the American health care delivery system was in place. It included a separation of insurance from the actual delivery of health care, but with both remaining primarily in private hands or control. With the small exception of charity care and some services provided for the military and veterans, health care was delivered on a free-for service market model where physicians enjoyed a significant amount of autonomy to provide treatment. As a consequence of World War II, health care insurance was offered by employers though employment and not provided as a universal condition of citizenship or based on medical need.

Health care policy in the United States evolved after World War II, laying the foundation for policy debates and reform that would continue to affect the United States up to the present. President Harry Truman's call for universal health care coverage in 1945 would dominate health care policy and reform for the next 60 years. It pitted two contrary ways to think about health care–as a fee for service market commodity or something that should be provided to all regardless of ability to pay.

In 1953, at the start of the Eisenhower presidency, 71 million or 44% of the population did not have health care insurance (Sullivan 2006, 17). Private insurance companies such as Blue Cross (originally founded in Dallas, Texas in 1929) expanded (Sullivan 2006, 14-15). By 1963, 63 million or 33% of the population lacked health care insurance (Sullivan 2006, 17).

As part of President Lyndon Johnson's Great Society social programs two major health care programs were adopted. The first was the Medicare program that provided health care insurance for the elderly (age 65 or older). Eventually Medicare was extended to cover the

disabled. Medicaid provided the same for the poor and indigent, especially those who were not working and ineligible for employer funded health insurance programs. Under the original Medicaid and Medicare plans, any individual who met the eligibility rules would receive free health care coverage. Both plans paid for health care on a cost or fee for service basis, allowing hospitals and other service providers to charge costs plus a 2% profit (Schulte 109).

Medicaid and Medicare served several objectives. They extended health care insurance to populations not served by the private health insurance. By the early 1970s they reduced the number of individuals without health care coverage to 10-12% of the population (Starr 2011, 5). Second, these two programs provided reimbursements to hospitals losing money on the charity care provision of Hill-Burton, a 1946 law providing federal money to encourage hospital construction. Three, it reinforced the fee for service of health care model in the United States and created incentives for health care providers to order additional services to maintain or secure profits.

Over time Medicaid and Medicare have become some of the largest expenditures and programs of the United States government. Medicare initially was budgeted for $1.6 billion, growing to $7.6 billion by 1970 (Schulte 127). By 2005 it had an annual budget exceeding $400 billion, insuring by 2008 more than 45 million individuals. Conversely, Medicaid is a joint federal and state program where states receive federal money if they wish to participate in the program. All states participate in Medicaid, but not all, as shall be discussed below, have decided to expand participation to cover more individuals under the ACA. In 2006 Medicaid expenditures were $320 billion, covering 55 million individuals in 2004 (Schulte 131).

These two programs are costly, and because of the basic fee for service reimbursement system employed, they have tended to encourage health care spending. As the number of elderly have increased along with life spans, Medicare spending has increased, creating a rising cost problem in the United States.

When Bill Clinton became president in 1993 it was clear that the United States health care delivery and insurance system was unsustainable. In 1992 during the presidential election the total population of the United States was 256,830,000. Of those 148,796,000 million were covered in private insurance plans (57.9%), another 66,244,000 were covered though Medicare, Medicaid, or the military (25.8% of the entire population). This left 38,600,000 or 15% of the population uninsured. This percentage had ticked up from 31,000,000 or approximately 12.9% in 1987.

Second, the percentage of the US GDP expended on health care had risen dramatically. In 1960 5.1% of the US GDP was spent on health care (Sullivan 2010, 20). In 1970 the US and Canada each spent about 7% of their GDPs on health care. In 1971 Canada instituted a single-payer universal coverage program. By 1990 Canada spent 9% of its GDP on health care, the US 11.9%, with 38.9 million uninsured (Starr 2011, 84). Canada's single-payer system contain costs, especially by reducing administrative expenditures. America's growth in the percentage in how much of its GDP it would spend on health care would continue to grow such that by 2008 it would reach 18%, 50% greater as a percentage of the GDP in comparison to other Western European or OECD economies (Starr 2011, 79). Compared to other OECD countries, the United States spent significantly more of its GDP on health care compared to Great Britain at 8.4% and Switzerland at 11.3% (Jacobs and Skocpol 2010, 21). Health care premiums for individuals, and

costs for medical procedures in the US, are among the highest in the world (Sullivan 2006, 42-43).

Third, the United States private insurance system was costly. Between 1987 and 1993, insurance premiums increased by 90% while salaries increased by 28% (Starr 2011, 79). These increases drove up the uninsured percentage. Finally, compared to other countries, the health care outcomes of the US were not necessarily better as a result of all the money spent (Woolf and Aron 2013). The US had an expensive health care system with limited access and impact in terms of making the public healthier.

In the 1990s President Bill Clinton pushed health care reform. His wife Hillary Rodham Clinton was put in charge of reform, but it failed. First, his proposals were damaged by his declining popularity and the Republican Party takeover of Congress in 1994. Second, interest groups, including the AMA, the health insurance companies, the pharmaceutical industry, and the American Hospital Association, opposed it.

More than a generation after the failed efforts by the Clinton administration to pass health insurance reform, the basic problems underlying American health care persisted. In 2008 15.4% or 46.3 million individuals in the United States lacked health care insurance. Two-thirds of the American public was covered by private insurance with a total of 58.5% receiving it through their employer (Census 2009, 20).

In 2008 the United States was spending 16.6% of its GDP for health care, approximately $2.4 trillion. Projections were that this would increase to 20% of the GDP by 2018, partly a consequence of the aging Baby Boom generation (born between 1946-1960) living longer than previous generations (Barr 2014), and because of the rising costs of medical technology (Lubitz

2005). Insurance premiums were also increasing in percentages far exceeding the rate of inflation or cost of living, resulting in an affordability crisis for both the United States as a whole and individuals and families.

As president Obama was i preoccupied with the 2008-9 global economic crash and turned health care reform essentially over to Congress. Unlike under Clinton, many of the major health care players such as the pharmaceutical industry, the private insurance companies, and the AMA eventually lined up behind reforms. These industries saw the addition of millions of newly insured customers would be profitable to them, or they received special rules that would be of benefit to them (Jacobs and Skocpol 2010, 70-71). The pharmaceutical industry would make billions of dollars from new customers, as well as some protections from the use of generic drugs. Bringing these groups into negotiations thus eased some of the opposition.

So why did the ACA pass as opposed to other efforts since the Harry Truman speech in 1946 calling for it? It had to do with the mounting costs of health care to businesses and families. There was buy in by major health care industry players and interest groups who expected to profit from the law (Brill 2015). Part of it was also due to Obama's and the Democrats' huge victory in 2008 and they put more effort into this reform than others problems (Starr 2011, 236-38). Finally, the relative modesty of the ACA, relying on use of private insurance, employer coverage and individual mandates, marginal expansion of current government programs, and an overall continued embracing of a market-based approach to health insurance all could be counted as factors explaining its eventual passage.

D. Major Provisions of the Affordable Care Act

The final version of the Patient Protection and Affordable Care Act contained several provisions to extend health care to cover the 47 million Americans who did not then have insurance. The law is a complex package of many provisions that use government and private insurance systems and market incentives to expand the quality and overall coverage and access to health care services. The ACA also contains provisions to address costs. The main provisions or points of the law can be grouped around a series of provisions (Kaiser 2011). The on-line appendix to this article provides more details on the specific provisions of the ACA. Three provisions are worth noting.

First, the ACA has an individual mandate requiring all US citizens and legal residents to maintain qualifying health care coverage. By "qualifying" the law specifies certain conditions and services to be provided in the policy. Second, individuals who do not have health insurance through their employer or the government will be required to purchase it or pay a penalty. Individuals who cannot afford to purchase health insurance will receive subsidies to buy a plan. Finally, the ACA mandated the creation of health care exchange by states. These exchanges would be places where individuals and business could shop for and purchase health care insurance. The exchanges create a site where purchasers can locate qualified health insurance plans and shop for the best priced plans that meet their needs. Between 2013 and through 2017 various rules regarding how the exchanges would operate, who could use them, and types of plans that would be available (such as multi-state plans) would eventually kick in or change. The exchanges would be operated by the individual states unless they decided not to do it and then the federal government would operate exchanges on behalf of the states.

E. Implementation History

Initial implementation of the Affordable Care Act got off to a difficult start, plagued by political, legal, and administrative problems that have had various impacts and results on the continued viability of the law.

The most significant variable has been its political opposition and lack of public support for the law. Right after its passage of the Act public opinion was divided in support (40%) and opposition (54%) (Starr 2011, 271). Specifically, 75% of Democrats supported the law, 80% of Republicans opposed it. The ACA passed without Republican Congressional support and opposition toward the law has become a politically polarizing issue.

This polarization lead to where only 14 states and the District of Columbia initially created their own health care exchanges. Republican governors and state legislatures have generally been unwilling to establish exchanges, leaving it up to the federal government to do that. Such partisan opposition to the ACA and refusal of many states to create their own exchanges was not anticipated and it forced the federal government into a situation where it did not expect–operating the vast majority of the exchanges and becoming a prime implementer of the law. The ACA really anticipated federal-state cooperation and in many cases this is not occurring.

Fourth, partisan opposition to the ACA led to numerous legal attacks (Starr 2011, 276; Jacobs and Skocpol 2010, 154-55). Led by state Republican attorneys general or governors, one argument was that the federal government lacked the constitutional authority to mandate that individuals purchase health insurance. **A second argument was that the federal government lacked the authority to require states to expand Medicaid coverage.** In *National Federal of*

Independent Businesses v. Sebelius (2012), the Supreme Court held that while the individual mandate exceeded the federal government's power under the Commerce Clause, the mandate was within Congress' power to impose a tax on individuals who were insured yet refused to purchase health insurance. However, the Court ruled that the federal government could not penalize states if they did not expand Medicaid coverage by withholding all Medicaid funding. This meant states effectively could refuse to expand Medicaid coverage to more uninsured individuals. In states under Republican Party control, this is exactly what has occurred, blunting the number of individual's that the ACA will cover (Barrilleaux and Rainey 2014).

A second challenge to the Affordable Care Act came from closely-held corporations contending that it violated their First Amendment Free Exercise of Religion, forcing them to pay for health insurance policies that provide for birth control or contraception. In *Burwell v. Hobby Lobby Stores* (2014) the Supreme Court agreed.

A third legal challenge addresses whether the ACA allows for subsidies to low income individuals who purchase health insurance through the federal health care exchanges. Some argued that the language of the Affordable Care Act only allows for subsidies in cases where states runs a health care exchange. In 2014 the D.C. Court of Appeals in *Halbig v. Burwell* issued a split decision invaliding the tax subsidies to individuals in states where the federal government was operating the health care exchanges under the ACA. A few hours later the Fourth Circuit Court of Appeals in *King v. Burwell* unanimously reached a contrary conclusion. In June 2015, the Supreme Court ruled in *King v. Burwell* that subsidies were available to qualifying individuals who purchased insurance though any exchange. Had the Court ruled contrary it would have potentially gutted as central feature of the ACA.

Despite these problems and others, by March 2015, 11.7 million individuals had health insurance though the exchanges, with 86% receiving subsidies, indicating that these are individuals who probably did not have coverage before because of cost (Pear 2015). There have also been mixed signals regarding cost projections (Bernard 2015). Third, one of the other main goals of the ACA was to reduce health care spending in the USA as a percentage of the GDP. Some argued that the ACA never really included significant cost controls (White 2013). However, there are indications that US healthcare spending has slowed, but the degree to which that is due to the law or the economy is not clear (Economist 2015). The ACA has not addressed the demographic issues surrounding the increased health care costs associated with an aging American population. It is also unclear whether the Act will be able to decrease individual premium costs for purchasers of health care insurance.

III. Health care in Russia

Russian society faces health care problems similar to many other modern societies, including the United States. Among the most important are an aging population, technological development, and rising costs of the health care (Stevens 2001). Health care in Russia has undergone constant reform in 20 years plus since the fall of the Soviet Union. Practically every year some changes in financing and organization of the health care system take place. The target of policy makers is the construction of an "effectively working" system. That means it should be inexpensive for the state, accessible to all the patients, based on modern technologies, and the quality of the service should be high.

A. The Context of the Russian Health Care System

The starting point for the contemporary system of health care in Russia is the Soviet system invented by N.A. Semashko in 1925 (Prohorov 2001, 16) according to the ideas of physicians proposed at the end of the nineteenth century. His ideas formed the basis of the system of health care in the Soviet Union. Soviet medicine was based on the principle of free access to all levels of health care (Dmitrieva 2001). Health care was financed from the state budget, Soviet people did not have to pay for medical service.

The main advantage of this model was the equality of access to free medical service for everyone. But the priority of the distribution of the resources was given to big cities versus small towns. The Soviet policy declared equality of getting medical aid for all citizens and in fact this principle worked: everyone could get medical aid in case of malady. As a result of the implementation of the model in the middle 1960s the expected average life expectancy for men in Russia was practically the same as in market-economy countries.

But beginning in the 1970s the healthcare system started to get less financing and support than in the years before. This was due in part to the fiscal pressures the Soviet Union was facing. By the 1980s hospitals' facilities had become too old. Because of lack of money, wages in healthcare shrunk, though it was never high. The Soviet system was thus criticized because of the lack of financing, including low wages of the physicians and lack of funds for facility innovation. All the problems of the quality of Soviet health care were practically always connected with finance. There were also non-financial problems that influenced the quality of medical service: including the harshness of medical personal and the bureaucratic approach to the patient (Prohorov 2001, 28-29.). Eventually by the end of the Soviet period the system lost

patients' confidence. There were no reforms in health care system during the soviet period and the system demanded some changes.

The breakup of the Soviet Union forced economical, political, and social changes and some of them touched health care system. The Soviet health care system was centrally run and depended on the national budget. Budget deficits were growing quickly during the last Soviet years: in 1985 – 2.4 % GDP, in 1986 – 6.2%. (Illarionov 1995, 4.) In 1991 the budget deficit was 31.9% GDP, in 1992 it was 14.2% GDP, the next 2 years it was nearly 10% GDP. (Illarionov 1995, 23.) Health care took 2.5 % GDP on average from 1985 to 1990 and after 1991 it was 3% on average. With the high deficit the financing was not enough for the population with an increasing death rate (in 1994 it was 32.6 % higher than in 1990), and mortality from infectious diseases (in 1994 it was 65% higher than in 1990) (Prokhorov 2001, 16.). The system also demanded new equipment and augmentation of physicians' salary: in the early 90s their salary was below the subsistence minimum (Prokhorov 2001, 33.). The financing of the system needed some changes and they were done in two directions: diversification of financial sources by the implementation of statutory and implementation of private insurance mechanisms and market principles and its elements in state sector to disburden some state's health care expenses upon patients.

B. Health Care in Russia from 1990 to Present Day: Implementation of Market Principles

The beginning of the changes in the health care system can be dated to 1992 -1993 when the first steps to the present statutory insurance were made (Babko and Orekhovskiy 2005). These changes were necessary as a result of the breakup of the Soviet Union, the dismantling of

its health care system, and the need to find a new way to bring medical care to Russian citizens in a post-communist era. One of the first documents developed to describe and plan the changes in the health care system appeared in 1997. It was entitled “The Concept of Health Care and Medical Science Development”. Among the main goals of the development of health care mentioned in the Concept was growth of the efficiency of use of resources.

The Concept provided 2 steps:

- 1 step (1997-2000): restructure of hospital care, creating day hospitals and the institution of general practitioners, standartization of medical service (1998);
- 2 step (2001-2005): developement of private sector in medical service, developement of interdistrict and interregional centers of specialized medical service.

Some of these plans were realized: medical service was standardized, the private sector was developing rather fast and 12 interregional centers of specialized medical service were created. The project of creating general practitioners was not successful and was given up soon. Among the main points of the Concept we can see the development of private sector and the restructure of the hospital care. These two measures are supposed to be steps for reduction of governmental costs. The central trend of the health care reforms of this period is the development of the private institutions. The Concept provided the measures to reduce the state costs by shifting heath care costs to the consumers of the services. Another important point was the enlargement of state medical centers and investing in its facility innovation. At the same time hospitals considered ineffective were closed or associated with larger ones. These steps from one hand were made to reduce state costs by stimulating the development of private sector and consolidating medical

institutions and from another hand they made the state health care system less accessible for the majority of population.

From 2004 to 2008 nearly 15% of ineffective hospitals were planned to be closed or reorganized. Also it was projected to change the legal form of some medical institutions, the changes meant the reorganization of some clinics in state (or municipal) self-contained non-profit-making organizations (Kommersant 2004). This form did not exist under USSR. State clinics as self-contained non-profit-making organizations can operate as an entrepreneurial business according to the main goal of the organization – delivering of the medical service. As a result state medical institutions became self-contained non-profit-making organizations and could give paid services. So in the state sector there appeared an opportunity to make profit in addition to budget financing. The attitude of patients toward paid service in state clinics was mostly negative: nearly 60% said that the quality of free medical service became worse (Sishkin 2008, 51). The development of the private sector was active in early 2000s: according to the federal statistics data, in 2001 the growth was 2,4 % but in 2002 the amount of medical services decreased by 5,6 %. The biggest amount of paid medical service was when private service was just implemented – in 2000-2001. Over the next 10 years paid service became the part of public economy but without growth. The development of paid services is negatively viewed by the majority of population: Russian people were used not to pay for medical care. Such attitude can be changed with the development of the legal base of private healthcare institutions and with the change of generations.

In 2006 among the objectives of the national project “Health”, which was started in 2005, President V. Putin offered some ideas for state health care:

- single-channel principle of financement, financement according to the service;
- competitiveness of medical institutions and the freedom to choose the doctor and the clinic;
- remuneration of labour of medical spesialists according to the result, professional development of physicians.

From this time the implementation of the principles, actual for business and private health care started in medical organizations. In this year medical-economic standards were proposed to fix minimal standard pattern of medical service. These standards mean free medical aid for particular illness, delivered by the state and approximate costs of treatment of these illnesses. It was a technological decision for the unification of the quality of medical service.

In 2007-2008 the transition to the new way of remuneration of labor of medical specialists in state sector according to the number of patients took place. The aim of the change was to motivate physicians to improve the quality of their work. (Selezneva, Sheiman and Sishkin 2010) This measure made the principles of management of state health care institutions closer to the principles of private sector.

In 2011 the Federal law “About the Fundamentals of Health Protection of Citizens of Russian Federation” (Federal law №323, 21.11.2011) was adopted. This law touches a great number of different issues. For example according to the law the patient can choose the clinic and the physician either in state or in private sector. Before it was impossible for state sector: every citizen could take medical service only in the organizations close to the place where he lived or connected with the organization where he worked. This law was an effort to implement

the principle of competitiveness in state health care delivery, to give patients more choice in selecting doctors.

Some of the principles of the healthcare mentioned in this law also declared accessibility of medical service:

- the priority of patient's interest;
- social guaranties of health care for citizens in case of disability; the impossibility to refuse to give medical aid – in fact these principles declared the access to medical service in case of need;
- state and municipal responsibility for the ensuring of human rights in the field of healthcare;
- accessibility and quality of the medical aid (quality means standards in health care service and the state-guaranteed services.)

On the other hand The Ministry of Finance plans to reduce the number of state clinics and physicians: from 2000 to 2013 the number of hospitals reduced from 10,704 to 4,398. (Kommersant 2015; Nikolaeva 2014) These measures are supposed to stimulate the development of private sector but in fact they are strongly criticized by patients and physicians for problems with access to the state medical service (Rybina 2014). It's the greatest paradox of the present situation.

Discussing the reforms of the last fifteen years it is possible to mention two directions or goals of reform:

1. Creating private medicine. The main goals of the implementation of private health care institutions were the reduction of costs and better access to health care service for all

citizens. Since 1997 in Russia there now exists private sector and private voluntary insurance and state clinics and government insurance.

2. Implementation of market and managerial principles in state clinics to rise their efficiency.

The most important problems of Russian health care while rebuilding the system were costs of medical system and its reduction and access to medical service. The second is mentioned several times in the latest law and the first is the basic goal of all changes: implementation of the principles of performance-based budgeting. The problems of reduction of costs and access to medical service are closely connected and they seem to be not solved yet. At the same time market principles were implemented in the system of healthcare delivery, this measure was not very successful because of the difficulties for the administrative and medical personnel of the clinics who were not used to market and management principles.

i. Costs

Financing was always the main problem of Russian health care. From 2006 to 2013 the financing of free health care increased 2.9 times (Gritsuk, Smolyakova 2014). The national project "Health" was expensive – 166 milliard rubles in 2012 and 176 milliard in 2013 (Lavrentieva 2012). The system of financing of health care changed from the Soviet period and now it is based on a system of statutory health insurance and subventions from the budgets of federal or regional level. The Statutory insurance fund distributes funds among regions according to the population, including the level of wages and the particularities of the regional health care budget. The costs of medical service in different regions depend on special tariffs. The process of

its elaboration is regulated on the federal level by statutory insurance fund but real values are set on regional levels. All regions have their special features which influence the tariffs: for example wages in Chukotka are three times higher then in Kalmykiya, transport accessibility is better in Kalujskaya than in the Vologodskaya region (Gritsuk, Smolyakova 2014). So the costs in different regions are different because of special characteristics of each region. The Russian state promises a lot of services and declares guaranties of free medical service but the financial coverage is too poor. This situation can be explained by the deficit of the territorial program of the state guaranties of the free healthcare in 66 regions. In 2013 the total deficit of the program of the state guaranties was 14,4 % (Korablev 2013). The difficulties of keeping the constitutional guaranties are evident.

Changes in 2014 mainly addressed the financing of medical institutions. Its main object was the minimization of costs. First, the cost reduction was supposed to be made by change of the mode of financing of clinics: from 2014 financing depends on the number of people who take medical service in the clinic, on the age composition of the population, its morbidity, but not from the services rendered. Some kinds of service will be paid according to the number of visits. For example antenatal clinics without regular patients. A clinic needs to have in average 5,000 regular patients.

Second, one of the measures to enforce cost containment is to decrease the number of clinics. The reduction is explained by “inefficiency” of clinics and small number of patients.

Third, one of the most important changes was the emergence of private clinics (Lavrentieva 2012). Now Russian health care system consists of state, municipal, and private clinics (Dmitrieva 2001, 327). State medical institutions are under federal or regional jurisdiction

and municipal institutions are under municipal jurisdiction. Paid medical service is a new way of functioning of the Russian healthcare system. This reform brought the market principles to the system which was not commercial during the soviet period. These measures were to solve the problem of finance of the medical institutions. Since 1997 the plan was to institute and to increase private sector (to let someone who can pay accept medical service in private clinics and to relieve state clinics from some costs), to increase the funds of health care (up to 6-7% GDP), and to increase the wages of physicians. The main goal was to change the spirit of the system from paternalistic to market principles.

From 2000 to 2012 people more and more used paid medical service. Paid service was growing all 12 years from 27,448 to 333,895 million rubles. That does not mean that private sector was growing fast: more and more people during these years started to use paid medical service in state clinics. For many people payment is a compulsory measure. Many of them pay for service in state clinics. Private financing is 40-50% (in the EU private financing averages about 24%) and it is a very difficult problem for poor people. Someone who use private medicine more often in case of illness pays for the visit to the doctor. Voluntary health insurance has not become popular yet (Selezneva 2015). Individual costs are growing. In state clinics in 2014 the number of patients who paid for the service was 12 % more than in 2013. Commercial service is more popular in Moscow, Saint-Petersburg, and Tatarstan, compared with another regions (Sishkin et al. 2008, Gritsuk, Smolyakova 2014).

Nevertheless 64% of medical services take place within the state sector (Lavrentieva 2012). After the research of Russian Public Opinion Research Center on demand of the High School of Economy (2013) physicians have critical attitude toward the health care management,

especially given their reliance for their salary from the working load and quality and the personal contribution. The special reason of negative evaluation of the situation is the unjust difference between salaries of health care managers and physicians (Temnitskiy 2015).

So the key problem of the Russian health care – the problem of lack of financing (Sheiman 2007, Chubarova 2008) – was not solved after all the reforms. How to spend less money for the service which is free for patients – that is the main question of reforms. The ways of cutting down costs of medical organizations are: changing the principles of financing according the number of patients, reduction of number of state clinics and the development of private sector to relieve state clinics. Meanwhile state health care has a priority in Russia, especially in regions, that is why the problem of saving money has yet to be solved. One of the ways to cut the costs is to cut the number of state clinics. This measure affects the access to the medical service, that becomes another problem.

ii. Access

There was no problem of access in Russian health care during the Soviet era. The question emerged during the last years when the number of clinics was cut down and it became not so easy to take a consultation of specialist.

When we speak about access to the medical service in Russia one needs to consider two issues: the number of free health care institutions to provide service: clinics, hospitals; and the list of free services. Why is it important to mention that the level of access can be measured by free services? For Russia it is so because free health care is mentioned in the 2 chapter 41 article of Russian Constitution as a right, though market principles are implemented and the system of

private health care exists, it is incorrect to say that they substitute state clinics. The basic part of population uses the clinics of state sector, even if they pay there for some service.

Patients can choose either state or private clinic for medical service. Voluntary insurance and development of private health care created alternatives in access to medical service: a patient can take medical service in state clinics without payment or pay and go to the private sector. Private clinics are not included in the state health care system and the mechanism of cooperation between private and state clinics does not exist. Experts mention that as a result of cooperation medical equipment of private clinics could be used for patients of the state clinics, who have to wait for special medical examinations for a long time. Now there are no mechanisms for realization of this idea, but the necessity of it exists.

Before 2010 the government planned to reduce hospital care by 30-35% and increase outpatient-and-clinic care to 55%. In 2013 76 clinics and 302 hospitals were eliminated. There were a total of 35 000 beds eliminated. The biggest reduction of the number of beds was in Volgograd Oblast, Tatarstan, Primorsky Kray, Sverdlovsk Oblast (Gritsuk, Smolyakova 2014). At the same time beginning in 2014, 459 high technological services were included in the statutory insurance system, so that they can be taken in regional clinics. Before it was possible only in federal clinics. So the situation with the access to these kinds of service has become better.

Some differences are caused by regional policy. For example in Tatarstan the main goal is to improve the access to medical service (The main principles of Tatarstan health care policy are declared in the governmental program “The development of the health care in the Republic of Tatarstan until 2020” (2014). The ministry of health care of Tatarstan elaborated the three

level system: the first level - 85 medical organizations for primary health care, the second level - 38 medical organizations with inter-municipal specialized centers or departments and city dispensaries and versatile city hospitals for specialized medical aid; the third level - 25 regional specialized medical organizations provided with high-technology equipment.

The idea of this three level system was to organize state medical organizations according to the complexity and technological level of service. The organizations of the first level for primary health care provide service which doesn't need high-technology equipment and the consultation of profile specialist. The organizations of the second level are provided with more equipment and medical specialists. The organizations of the third level are big centers with high-technological facilities for diagnostics and treatment. Patients firstly visit clinics for primary care, then if necessary the physician gives appointment card to the profile specialist to the clinic of the higher level.

This system doesn't give people more accessibility then before or in Soviet times because the time of waiting for the consultation or the procedure became longer and the number of specialists and clinics is cut down. The level of access for people who can't pay is becoming lower. And for those who can pay it will not change a lot.

iii. Outcomes

Russian people were used to the free health care system in the Soviet days. According to a telephone survey in Moscow in 1991, 83,6% answered that they would be ready to pay for the right to choose a physician and private clinic instead of going to state clinic (Dmitrieva 2001, 327). The private clinics appeared and the real situation was differed from the survey responses

and opinions expressed in the early 90s. The dynamic over time has shown that the attitude towards private medicine has changed and Russians tend to visit state clinics instead of private ones (Dmitrieva 2001, 328). The actual situation or practice of Russians demands increased personal responsibility for health, yet at the same time the system continues to lose peoples' confidence and respect. Only big centers which combine theory with medical practice are able to keep high quality of service. On the whole the attitude of people towards the health care system remains skeptical.

Mainly the different attitudes can be explained by the personal experiences that everyone have with securing health care or in their actual visits for services. Having bad interactions with the health care system lead people to start to search for more information about their diseases: TV-programs and Internet-pages about health have become very popular over the last 10 years. People are withdrawing from the state clinics and either from private clinics seeking for medical help in the Internet, TV and addressing to alternative medicine. It's hardly possible to evaluate the market of alternative medicine because many organizations work without registration. But some people even try to cure their illnesses themselves or do nothing. One of the reasons for this behavior is that people don't trust physicians because of previous bad experiences (Krasheninnikova 2014).

The attitude of the society to the private medicine is different: some patients are sure that the quality of service is higher than in state clinics. Some say that the quality is not always higher and doctors in private clinics provoke more unnecessary expenses. In 2015-2017 the demand for private health care is forecasted to decrease (Korneeva and Samsonova 2015), and its integration in the system of statutory insurance seems to be one of the perspectives of development of

private health care market in Russia. It can be considered as one of the ways of improving the effectiveness of both state and private health care by engaging state sector in concurrence with private.

There are two approaches to the health care: a collectivist approach, that means free state medicine for everyone and individual approach (Stevens 2001, 162), that means paid medicine, independence of choice of the clinic and personal responsibility in the health care. Russian health care reform can be considered as the attempt to combine these two kinds of healing systems: statutory health insurance and private medicine, declared priority of prevention measures and increasing tendencies of self-responsibility and even self-treatment. In Russia we can see the convergence of two models: the base of the system is a collectivist model with guaranteed free medical service and we also see the implementation of some market elements, including private clinics, elements of concurrence in health care. This eclectic model was made to avoid the weaknesses of each model. It will take some time to understand which of them are suitable for Russian society and which are not. The reforming should be stopped and the societal self-regulative processes will show the main disadvantages and ways of its correction.

IV. Conclusion: Comparative Analysis of Health Care reforms in the USA and in Russia

The US and Russian began the 1990s with contrasting health care delivery systems, facing similar challengers in terms of costs, coverage, quality, and access. What do we learn from a comparison?

The two countries have contrasting approaches to the health care system: an

individualistic, market-orientated or fee for service one is closer to the USA and collectivist approach with centrally run health care system and statutory health insurance as the most popular insurance model is closer to Russia. The Russian health care system faces a cost problem: the number of state clinics and hospitals have been reduced, yet medical centers have high-technology equipment. The United States too faces a cost problem both in terms of an overall percentage of the GDP and the cost to individuals.

Second, for the USA, access is an major issue. The USA is trying to solve this problem first by increasing coverage in the private insurance system through the creation of health care exchanges or secondarily through government programs. In contrast, Russia is building an alternative private health care insurance and delivery system to reduce public expenses and to create competition.

Third, in Russia the main direction is administrative rebuilding of its health care system is the reduction and joining clinics. In contrast, in the USA the most important reform is insurance, not in the actual delivery of health care services.

Considering these differences, one sees a convergence of healing systems and the tendency to adopt similar principles. For example the principle of individual responsibility in choosing clinic and insurance programs is common for the USA and Russia. The Russian health care system is developing private insurance mechanisms; this process is already started but it needs more time to develop. Both Russia and the United States are relying on the improved efficiency of the private delivery of health care or insurance to address problems that they face. Both countries appear to be trying to use market principles to reduce costs, increase access, and improve quality. This should not be a surprise; both countries are facing similar problems and

therefore the mode of functioning of two systems based on market principles is becoming more and more similar.

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