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SOCIAL HEALTH INSURANCE IN UKRAINE: WHY (NOT)?

The health care system in Ukraine suffers from a lack of funds, quality and efficiency. Currently, Ukraine is debating a system of social heath insurance. In this paper we discuss a few of the problems that have to be faced when introducing social health insurance: the collection of (sufficient) revenues and distributional issues related to the contributions for health insurance, the importance of risk sharing among (regional) health insurers in order to create stability in the system, and the definition of entitlements, i.e. what should be included in a social health insurance package and what should be left to voluntary supplementary insurance?

Introduction

The health care system in Ukraine suffers from a lack of funds. Partly as a consequence of this the quality and efficiency of the health care system leaves much to be desired. According to UNDP data in 2000 health care expenditures per capita amounted to a mere 152 US dollar. This is extremely low, even compared to countries where the economic and social conditions are similar to those in Ukraine. For example, health care expenditures in the Russian Federation were 405 US dollar per capita, i.e. more than two and a half times as much as in Ukraine. Western European countries typically spend between 2000 and 3000 US dollar per capita on health care. Not only in absolute amounts, but also as a share of total national income, expenditures on health care are low. Total public and private expenditures on health care took up 4.1 % of gross domestic product (GDP) in 2000, whereas the Russian Federation spent 5.1 % of GDP and most Western European countries spent close to 10 % of GDP on health care [1].

The health state of the population is a cause of great concern. For example, the prevalence of HIV/AIDS in the population aged 15-49 years is 0.99 (UNDP 2003). This is high compared to the HIV/AIDS prevalence in Central and Eastern European countries (0.50) and Western European countries (0.30). Also the prevalence of tuberculosis in Ukraine is with 57 cases per 100,000 people higher than in Western European countries (9 per 100,000), but not higher than in all Central and Eastern European countries taken together (66 per 100,000). The infant mortality rate is with 17 per 1000 births also higher than in Western Europe (5 per 1000). The same holds for the under-five mortality rate: 20 per 1000 in Ukraine against 7 per 1000 in Western Europe. Finally, the probability at birth to survive until age 65 in Ukraine is 81.1 % for women and 56.5 % for men. These survival rates are again much worse than in Western Europe, where typically 89.5 % of women and 80.9 % of men survive until this age [2].

The potential for a substantial increase in resources for health care in Ukraine appears to be small. GDP per capita in 2001 in Ukraine amounted to 4,350 US dollar. Again Ukraine compares unfavorably to a country like the Russian Federation in this respect where income per capita was 7,100 US dollar. Incomes per capita in Western European countries typically are in the range between 20,000 and 30,000 US dollar [3].

The relatively low level of GDP makes it very difficult to free more resources for health care. This may - at least partly - explain why improvements in health care delivery are primarily sought in a restructuring of the health care sector.

One of the major concerns in Ukrainian health care is the inadequacy of financial risks protection: the capacity of a health care system to protect individuals against the serious financial burdens that disease can produce. Financial risks protection of the patients in Ukraine, in fact, is not guaranteed although it is part of the Ukrainian Constitution. Free medical care is delivered more and more rarely because of insufficient budget expenditures, unjustified high costs of the health care, and low salaries of the personnel. It is often reported that the health systems survive on informal (unofficial) payments to health care providers. Patients pay out-of pocket for treatment, drugs, and stay at the hospital. A study in Ukraine reported how wide-

spread under-the-counter payments are and how medical personnel receive these unofficial payments - in 66 % of cases the patients knew that it was necessary to make a payment, and in 25 % of cases the doctor requested (or hinted) to the patient specifically for a payment [4-7].

Paid services are not affordable for the majority of the population. Inequity in access to health care has become a serious problem. A survey in Odessa region of Ukraine in 2001 showed that 27 % of families had a family member hospitalized in a one year period, 4 % of the families surveyed were referred to a hospital but did not accept because they did not think it would improve the condition, 13 % of families could not afford the care when they were referred, and 56 % did not need hospitalization [8]. According to the data of another survey, which was conducted in October 2002, 27,5 % of 47 800 households reported they could not get needed healthcare for family members [9].

A study in the Odessa region found that the percentage of the family budget spent on health care was much higher in low-income families [10]. The research data, obtained by the World Bank Institute in countries with the transitional economy demonstrate the impoverishing effect in case of serious long-term illnesses. It has been shown that the utilizing of medical care is lower among the people with lower income. It causes complications, chronic cases, requests the long-term treatment and costs more. The lack of preventive strategies also makes a contribution into decreasing the health status and increasing of financial risks of patients [11].

Besides suffering from a lack of funding, the deficiencies in financial risk protection and rising inequality in access to health care, the old system of hospital health care financing based on line items budgeting is also costly and technically inefficient. Moreover, the allocative inefficiency is a major issue as 80 % of health care expenditure spend on inpatient care while only 5 % spent on primary health care (rest 15 % spend on specialized outpatient care) [12]. The inadequacy of salaries leads to reduced motivations, staff absence and low quality care, and often corrupt practices such as leaking recourses and demands to patients for under-the-table payments [13].

As a result of all of this the quality of health care delivery is sometimes poor and inadequate. Physicians and hospitals are poorly motivated and sometimes lack in professional attitude and behavior, materials and equipment are outdated or worn-out, and hospital buildings and facilities no longer meet the requirements of modern day health care.

There is an urgent need to ensure financial protection, a sustainable financing of healthcare in Ukraine, and an improvement of the quality and efficiency of health care in Ukraine. Like many other Central European countries, Ukraine is debating the implementation of a social health insurance. Plans for a social health insurance system are loosely based on systems of social health insurance in Western European countries. Copying a system of social health insurance from Western European countries is not without risk. It is also doubtful whether a system that works well in Western Europe - many Western European countries are in a process of reform of their own social health insurance systems as well - will produce equal results in Central European countries. For one thing systems of social health insurance have taken many decades to evolve in Western European countries. These systems also cater to the needs and the social environment of societies in Western Europe. These needs and social conditions in many aspects differ from those in Central European countries. Among others, standards of living in Central Europe are still dramatically lower than in Western Europe, unemployment is much higher, poverty is much more prevalent and the health status of the population is generally much worse. These are only some of the differences in social conditions that affect the introduction of social health insurance and make that the possibilities and the effects of the implementation of social health insurance in Central Europe differ from those in Western European countries.

Will the adoption and implementation of the Draft Law of Ukraine "On health financing and medical insurance" increase resources for health care financing and contribute to improving health care? The "Financial and economical justification" of the Draft Law provides the arguments on how and why the health care financing will increase. According to that estimation both health care financing and expenditure will increase twice (as for one citizen of Ukraine in 2003 from $32 to $69 - according to the Ministry of Health of Ukraine).

In general health care financing could be almost $3 000 000. The structure of "new" potential incomes to health care from different sources according the Draft Law looks as following: 73 % - employers for their employees, 19 % - Pension Fund for pensioners including disabled people, 4 % - Unemployment Insurance Fund for unemployed and 4 % - local authorities for self-employed.

So, the financial burden of social health insurance lies down on officially employed. According to the Draft Law employers and local authorities will pay main contributions to the Social Health Insurance Fund for citizens employed in official sector. Employers are expected to pay from the "salary funds", which would unlikely is popular among the employees. As local authorities are supposed to pay 100 % premium for self-employed citizens (free lance workers, entrepreneurs, etc.) from business income tax the tax rate must be increased.

Let us assume that the Pension Fund and the Unemployment Insurance Fund will pay regularly for pensioners and unemployed. But Funds are composed from the taxes paid by employed people. At the same time the significant amount of funds are concentrated in the informal or black sector as 21 million from 28 millions of employable population are busy in the official sector.

So, will it be possible to pull resources for the Social Health Insurance Fund if we relay on employable population working in official sector? Will they be still willing to work in official sector? The package of services must be determined; but the majority of services will require payment/co-payment. It is easy to predict that many people will be negative about social health insurance and co-payments.

So-called "State Program of Medical Provision" suggested by the Draft Law gives some confidence, as it could provide "lifesaving" level of health care for all citizens [14].

In this paper we offer a critical account of the plans to introduce social health insurance in Ukraine. As the specifics of the social health insurance system are as yet unclear and the necessity of a social health insurance system is still debated, this paper will focus on the need for a system of social health insurance and on some of the options and pitfalls that surround such a system. In this way this paper may contribute to the discussion whether a social health insurance system should be implemented and if so, how the system should be devised.

The "why" and "how" of social health insurance

Funding of the insurance system

An insurance contract is a contract between two parties whereby one party — the consumer — pays an amount of money for certain - the insurance premium - to the insurance company to cover the costs of uncertain events in the future. With insurance the amount of money paid for certain is related to the expected cost of the uncertain events. This relation is violated in several ways in social health insurance. Contributions to social health insurance are usually not related to expected claims on the insurance company (ex post income transfers between low risk and high risk individuals). Furthermore, contributions are often related to income (ex post income transfers between high and low income earners).

Social health insurance is essentially nothing more than a way to separate funds for health care out of the government budget. By separating them discussions on whether to spend money on health care or on education, or policing or other public sector activities is avoided.

Social health insurance is usually funded by premiums levied on employers and employees and by state contributions. Funding through premiums paid by employers can have several adverse effects however:

1. In a situation where the tax base is already eroded because employers do not pay taxes for their workers and many workers are employed in the informal or black sector, the revenues gathered through social health insurance premiums levied on employers are likely to be only small. Premiums levied on employers are therefore likely to result in underfunding of the health insurance system and to generate fewer resources than expected.

2. Premiums levied on employers increase the marginal tax rate on labor. This provides an incentive to employers to hire workers in the informal or the black sector, and will push out workers from the formal sector. As a result total tax collections may even decrease as a result of the higher tax rates because of social health insurance.

3. Economic activity is not spread evenly across the country. In some regions there is more economic activity than in others. Consequently, tax revenues in some regions are higher than in others. A regionally divided funding of social health insurance through social health insurance levied on formally paid wages, will result in an very uneven collection of revenues. In some regions social health insurance funds will be able to collect more money than in others. As a result you get rich and poor social insurance regional social health insurance organizations. One way to avoid this is to organize risk sharing among insurers - for example by setting up a general fund where all contributions to social health insurance are received, and from

which regional health insurance organizations receive their funding. We will come back to this point below.

Health insurance funded by taxes levied on labor earnings is unlikely to generate sufficient resources as long as Ukraine has a large informal sector and high unemployment. Taxes on labor earnings actually provide an incentive for hiring workers in the informal rather than the formal sector and - as they increase wage costs - reduce employment and lead to an increase in unemployment. Rather than funding through taxation of labor, the options for other forms of funding should be explored. An alternative source of funding is through commodity taxes levied on goods, the consumption of which that impose a health hazard, i.e. taxes on cigarettes and alcohol.

What will be the distributional effects of social health insurance funding

Premiums levied on taxable income will result in a redistribution of income from people earning taxable income to people who do not. The latter group also includes people who do receive and income, but who do not pay taxes (i.e. people earning an income in the informal sector).

A defining characteristic of social health insurance is that it involves income transfers from people with a low risk of claiming health insurance to people with a high risk of using health care (risk solidarity), and from high-income earners to lower income earners (income solidarity). However, the effects of social health insurance on income distribution not only depend on whether health insurance premiums depend on expected claims (experience rating) or income, but also on the type and size of co-payments.

The distributional effects of social health insurance are not only affected by the financing mechanism. Other factors play a role as well, such as the existence and the structure of co-payments by patients. Co-payments are a form of risk sharing on the part of the insured. Below we will also discuss risk-sharing mechanisms among insurers.

Different forms of co-payments can be distinguished:

- a deductible which patients first need to exhaust before the insurance company pays the bill;
- risk sharing, where patients have to pay a fixed amount of money for each service or a certain percentage of the costs they make. Further risk sharing can be unlimited or bound to a maximum amount of money patients have to pay each year.

It is clear that the distributional effects of each of these co-payment mechanisms can be quite different.

How to set up a general insurance fund

Important point here is how to determine allocation of funds to regional social health insurance organizations. An important point for consideration in the financing of social health insurance is risk sharing on the part of the insurers. Inadequate risk sharing or the lack of it have resulted in the failure and bankruptcy of many social health insurance institutions in Central European countries during the past decade.

The purpose of risk sharing is to reduce incentives for selection by insurers (so called "cream skimming") and to ensure the solvability of the local insurance companies by creating a general or central insurance fund in which all contributions to the funding of social health care are received. This is particularly important with regionally divided social health insurance. With a regional division in social health insurance companies, insurers in rural areas typically have higher than average costs (as elderly people and handicapped people are more likely to live in rural areas than in large cities where cost of living is higher) and lower revenues (as most of the economic activity is concentrated in large cities and average income per capita tends to be lower in rural areas). So, without some risk sharing, social insurance companies in rural areas tend to run in financial problems, whereas those in more urban areas tend to have relatively more resources to spend on health care.

Risk sharing and capitation payment are two methods to reduce risk selection and to ensure the viability of regional health insurance companies. With capitation payments, all revenues are put in one general insurance fund and each regional insurance company receives a certain amount of money for each of its insured consumers. The size of this amount per capita can differ between insured consumers. In general prospective and retrospective capitation payment systems can be distinguished. With prospective capitation, the general fund gives an amount of money to the regional insurer depending on the expected costs of the insured consumers. The level of this capitation is usually determined by observable characteristics such as age, gender, and health care consumption in the past. With retrospective capitation payment the regional insurer gets its actual costs reimbursed by the general insurance fund. The major differ-

ence between prospective and retrospective capitation is that with prospective capitation the financial risk - the risk that actual costs differ from expected costs - lie with the regional insurance company, while with retrospective capitation this financial risk lies with the general insurance fund. As a result prospective capitation provides strong incentives to regional insurance companies to become more efficient and to ensure that actual costs are less than expected costs and the level of capitation. Retrospective capitation, however, provides incentives for moral hazard from the side of the regional insurer and will lead to higher costs for health can than necessary.

How to define the benefit package

A very difficult issue in social health insurance is to decide entitlements: what should be in a package of social health insurance and what should be left to supplementary insurance or should not be covered at all. In the beginning of the 1990s the Dutch government committee - named after its chairman A. Dunning - published some criteria to determine whether medical services should be included in a benefit package of social health insurance. Essential these criteria can be seen as guidelines for priority setting in the allocation of public money for health care. The Dunning Committee proposed so-called "community-oriented approach" for establishing the necessary and unnecessary services. Three groups of services that would be provided were distinguished as follows:

- services useful to all members of the community, which guarantee a normal functioning in the society (such as nursing homes and care of the mentally handicapped);

- services useful to all members of the society, but mainly aimed at maintaining or restoring the ability to participate in social activities (emergency medical services, prevention of communicable diseases and facilities for acute psychiatric patients);

- services for which the necessity is determined by the severity of the disease in question and by the number of patients suffering from the disease.

The second sieve would select effectiveness on a scale which ranges from confirmed and documented effectiveness, through assumed and poorly documented, to non-demonstrated effectiveness, and confirmed and documented ineffectiveness. According to the Committee, only care that has been confirmed and documented as effective is a part of the basic package. The third sieve would select on the basis of efficiency, using cost-effectiveness and cost-utility analyses. The fourth sieve would retain care that may be left to individual responsibility. The Committee believed that one could set limits to solidarity when costs are high and the chances of a good outcome very slight.

After the publication of the report of the Dunning committee some attempts were made to implement the decision criteria. It proved to be difficult, however, on the basis of the Committee's criteria, to leave complete or parts of the services out of the basic health insurance. Although the Dunning criteria are appealing and acceptable in principle, their actual implementation is much more difficult.

It is possible to classify social health insurance systems by: 1) the type of health care goods included in the plan, 2) the extent of the compensation and 3) the type of provider of health care. The social health insurance package is best defined by looking at what is *not* included in it. In most countries the social health insurance system does not provide comprehensive coverage, however, the insurance companies do not reimburse the full cost of medical care. Items not included in a social insurance package are usually part of a package of supplementary health insurance. Countries differ in the type of costs that are not covered by the social health insurance system. As a result supplementary health insurance systems can take many different forms. In general, supplementary health insurance systems can be classified in three different types: 1) systems in which insurance against the costs of some health care goods are covered by supplementary health insurance; 2) systems in which supplementary health insurance provides additional insurance for co-payments in the social health insurance systems; 3) systems in which supplementary health insurance can be taken to bypass the health care provided for by the social insurance system. What the supplementary health insurance systems have in common, however, is that the insurance is optional and not, like social health insurance, compulsory.

There are various reasons why social health care systems do not provide comprehensive coverage. These objectives for a large part depend on the type of supplementary health insurance system involved. Objectives that can be achieved by one type of supplementary health insurance may not be attainable with other types of supplementary health insurance. For this reason there usually is a close connection between the structure and form of the

supplementary health insurance and the goals policy makers want to achieve by allowing for supplementary health insurance.

The first type of supplementary health insurance we distinguish provides insurance against health care goods that are not covered by social health care insurance. In general this may take two forms. One is a system in which basic or necessary health care goods or services are not covered by social health care insurance. Individuals can take supplementary health insurance to cover the costs of these basic goods. One example is the costs of dental care that are not covered by social health insurance in Germany and the Netherlands.

The other is a system in which so-called "luxury" health care goods are not included in social health care insurance. These "luxury" goods may include having a private room in a hospital rather than having to share a room with others, or the opportunity to see the professor or the head of the department in an academic hospital rather than being examined by one of the staff members, or being able to make an appointment to see a physician rather than having to wait for your turn during the consulting hour.

The second type of differentiation is by the extent of the compensation. Again, two forms can be distinguished. In the first there are limitations in the social health insurance system on the quantity of the services consumed and the supplementary health insurance provides coverage for additional consumption. For example, the social health insurance system sometimes limits the number visits to physiotherapist or psychiatrist. Or, the social health insurance system does not cover non-standard or irregular medical practices.

The second form is one in which there are limitations on health care expenditures in the social insurance system and where supplementary health insurance provides coverage for additional expenditures. More specific, this is a form where there are co-payments in the social insurance system when individuals can buy supplementary health insurance to cover these co-payments. It may be argued that the first type of supplementary health insurance we distinguished (supplementary health insurance provides coverage against health care costs that are not covered by the social health insurance system) is a special case of this form of supplementary health insurance, i.e. the first type of supplementary health insurance provides coverage for health care costs for which there are 100 % co-payments in the social health care insurance system. However, for analytical reasons, we believe that it is relevant to distinguish these two types of supplementary health insurance.

The third type of differentiation is by the kind of health care provider. In particular, supplementary health insurance can be used here to by-pass the social health care system. This is a typical characteristic of the British health insurance system, where individuals have the option to buy additional insurance that provides entrance to the private health care sector on top of their compulsory (tax based) contributions to the social health care insurance system.

Conclusions

Social health insurance is not a panacea, i.e. a cure for all diseases. With social health insurance funds for health care are separated (and thereby insulated from) other public sector expenditures. It also implies that decision-making in health care is - at least partly - shifted from the government to private of quasi-public institutions (the health insurance organizations). Some might view this as advantages. However, these changes do come at a cost. Firstly, the cost of organization and management of a social health insurance system is probably larger than that of a state-run system. The importance of a well-trained and experienced staff to manage and administrate social health insurance organizations should also not be underestimated. Secondly, a stable system of social health insurance makes high demands on organizational and management skills and requires careful decision-making by policymakers.

In this paper we have discussed only a few of the problems that have to be faced when introducing social health insurance. Three important problems stand out:

- the collection of (sufficient) revenues and distributional issues related to the contributions for health insurance;
- the importance of risk sharing among (regional) health insurers in order to create stability in the system;
- the definition of entitlements, i.e. what should be included in a social health insurance package and what should be left to voluntary supplementary insurance?

An open and thorough discussion on these topics is necessary before any irrevocably decisions are taken. Finally, it should be kept in mind that social health insurance may provide the conditions for the structural underfunding, inefficiency and

lack of quality in the health care system, but social health insurance in itself does not provide a solution for the problems that face the health care system in Ukraine.

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СОЦІАЛЬНЕ СТРАХУВАННЯ: ЧОМУ (НІ)?

Розглянуто передумови введення соціального/загальнообов'язкового медичного страхування в Україні з огляду на показники здоров'я населення, необхідність захисту пацієнтів від фінансових ризиків, соціальну справедливість у наданні медичних послуг. Прокоментовано, яким чином проект Закону України «Про фінансування охорони здоров'я та медичне страхування» здатний забезпечити стабільне фінансування галузі. Розглянуто теоретичні засади введення соціального медичного страхування, в тому числі з досвіду інших країн.