Reforms of the Russian medical system and their impact out to 2020

Prof. Igor Sheiman,
NRU HSE

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Changes in the structure of service delivery: strengthening PHC

Current situation:

-district physicians and GPs account to only 16% of physicians supply vs. 30-45% in the European countries

-low competence – low patients' trust (only 14% are happy)

-emphasis on curative rather than preventive functions

Strategy-2020:

- Programs of phased out district physicians upgrading : a) GPs, b) 2-3 categories of DPs with extended functions
- Take on from 30 to 70% of outpatient specialists functions, play the role of gatekeeper and coordinator of specialty care
- Developing chronic disease management programs (in addition to the current "dispanserization")
- Shifting from FFS to capitation payment, including GP as fundolder

Restructuring inpatient care delivery

High requirements to appropriateness of admissions (admission rate – 21 vs 14-19 in OECD countries

-deploying outpatient care departments in hospitals
-expanding the number of day care centers
-decreasing bed supply

Decreasing average LOS (12,4 days vs 6-9 in OECD countries)

- Differentiation of bed supply based on the intensiveness of inpatient care (long term care and acute care)
- A shift to DRG system of payment

Integration of service delivery

- **New regulation of continuity and coordination of care**
- **Methods of bundled payment**

Health labor policy accents

Overcoming disproportions in physicians supply between:

- **GPs and outpatient specialists**
- **Outpatient and inpatient physicians**
- **Various specialties (dominate specialties that serve private patients)**
- **Urban and rural health workers**

New model of postgraduate education

- CE rather than once a 5 years period
- Medical facilities act as purchasers of educational programs
- Best medical facilities are allowed to provide education in addition or instead of the current postgraduate education facilities
- Periodical certification of physicians

A shift to the "effective contract" :

- Performance-based contract with each medical worker
- Contract that allows high level of remuneration on one job
- **Contract that takes into account performance of the facility (not only individual)**
- **New targets for the level of remuneration by 2018**

Dimentions of effective contract

Remuneration related to the average in the region, %

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Physicians	115%	129%	143%	158%	172%	186%	200%	200%	200%	200%
Nurses	68%	73%	73%	84%	89%	95%	100%	100%	100%	100%

Average remuneration, thous. roubles a month

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Physicians	28	36,6	45,5	55,9	66,2	78,0	90,8	93,1	97,6	104,5
Nurses	17	20,7	23,2	29,8	34,4	39,7	45,4	46,6	48,8	52,3

Current problems of effective contract implementation

Visible increase of the remuneration size

But:

- Poorly related to performance
- Risks of decreasing non-labor expenditures

Prospective area: testing risk-based model of mandatory health insurance

Insurer

Bear financial risks (currently it does not) , therefore is motivated to be informed and efficient purchaser of medical care

- Collects additional funding (insurance premium)
- Within the premium:
  - *Bear risks for the established share of deviations between actual and planned expenditure*
  - *Allowed to keep the surplus*
- Commission high-performance Заказывает объемы медицинской помощи у медицинских организаций, способных обеспечить более высокий уровень качества услуг и относительно меньшие расходы (например, заказывает услуги дневных стационаров вместо круглосуточных)
- Контролирует обоснованность оказываемой помощи (в частности, госпитализаций)

Insurance premium

Capitation based funding