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How Public/Private Mix in Health Care Financing and Delivery Shape a Health System Structure and Outcomes: a Case of Russia

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Abstract

Health reforms are at the forefront of modern health care systems development for many well-documented reasons. The limits of public funds that can be mobilized and allocate to health care in modern capitalist society put high on political agenda the problem of finding resources enough to satisfy raising health needs and using the available funds more effectively. One way is to increase the share of private finance and delivery in more or less "socialized" (tax-funded or social insurance) health systems, but this is likely to negatively affect access to health care without significantly improving quality of treatment.

Development of public/private mix in Russia is influenced by both the Soviet history of health system development and societal reforms undertaken during transition period, the general trend however being less state participation and increased private mostly out-of-pocket spending. The paper analyses the existing public-private mix in health finance and delivery in Russia including introduction of fee for services in state health services and raise of private sector in health care delivery and how it might affect access. The research is based analysis of both literature and official statistical data available on the subject and results of various sociological survey conducted by research groups or commissioned by official bodies, such as Ministry of Health and Federal State statistical agency (Rosstat).

Taking into account the "sustainability" low level of public health expenditures coupled with high income inequality, it is suggested that certain groups of low-income people in Russia, first of all low income and living in remote areas are likely to experience problems in obtaining medical care. This situation provides for a new role for the government to control not only public but also private health expenditures as well in strengthening state administrative capacity in the course of public sector reforms with the view of securing people's access to health care.

Introduction

Health sector reforms in developed countries are centered on both population health status and cost containment aiming to solve a difficult task of meeting patients' needs at a reasonable cost. In this context the composition of public/private mix (PPM) is important as a way to get maximum outcome of the limited resources that modern society can allocate to health care.

The very nature of health care makes a role of the government in providing medical treatment important. However, recently the debates in health policy shifted toward possibility and necessity to increase the input of other partners, first of all private ones into health care system with the view of improving quality and efficiency, patient choice as well as attracting additional resources for health

system (Buso 2004). This development should be considered within a broader framework of growing influence of private sector practices on the performance of the public sector reflected in quasi-markets and new public management ideology.

An increased role of private sector in health care raises the problem of how to find a proper balance in PPM so not to compromise equity and access in changing landscape of financing and delivery of medical treatment.

Russia passed principal reforms in health care as a result of transition from centrally planned to a market based economy and political democracy (Chubarova Grigorieva 2014). They inevitably led to dramatic economic and social changes and formation of private sector non existent in Soviet times. In health care the process was not so quick as in other areas but nevertheless the scope and influence of private sector gradually is increasing both in term of private finance and private provision of health care.

The aim of the paper is to analyse the existing public-private mix in health finance and delivery in Russia from the point of view of its influence on health care system structure and outcomes for patients. It is based on analysis of both literature and official statistical data available on the subject and results of various sociological survey conducted by research groups or commissioned by official bodies, such as Ministry of Health and Federal State statistical agency (Rosstat).

The paper consists of three parts. In the first part a brief overview on PPM from theoretical and conceptual perspectives is presented that aims to provide a methodological basis for the study. The second one outlines the main characteristics of the public/ private mix in Russian health care along the two main dimensions of health system, namely organizational and financial. In the third part an attempt is made using the existing evidence to evaluate its impact on health care system functioning and outcomes it produces for patients.

Public/ private mix: methodological approaches

According to WHO, PPM may be defined as context-specific approaches to involve all relevant health care providers - public and private as well as formal and informal - in the provision of quality-assured health care (WHO 2009). Though

this definition was elaborated in connection with fighting TB, to our mind it can be applied to the health system as a whole. It stressed the importance of engaging all care providers and enhanced collaboration among them in various settings.

WHO also points to a significant variety of private providers to include, for example, private clinics operated by formal and informal practitioners, institutions owned by private, voluntary, and corporate sectors (e.g. non-governmental organizations (NGOs); faith-based organizations; railway health services; and health-insurance organizations).

In health care systems the changes in PPM are also attributed to global challenges that they face. The literature usually stresses population aging, increase in innovations in health technology, including new drugs and information technology, as well as intensified exchange of information and raising patients' demands and expectations.

It should be noted that health systems in modern world are nowhere pure models but rather complex mixed systems. The role of private finance and provision is often used as a criterion in elaborating health systems classifications. Chubarova suggests a classification that incorporates not only PPM but a broader societal environment (Chubarova 2009).

The general ideas behind modern attitudes to PPM are mixed economy of welfare and pluralism. Mixed economy of welfare assumes that welfare of citizens is provided by various actors, thus it does not matter much what is the source of welfare rather what matters is that the need is satisfied. Thus, the understanding of welfare state is expanding meaning efforts of all actors rather than government *per se*.

Pluralism has many definitions and is considered as a political concept in a democratic society that in PPM context implies several issues, namely:

- it allows for co-existence of various organizations and groups that keep their identities while existing with other groups;
- it recognizes competing interests when different groups can voice their opinions and ideas.

Thus, pluralism means that different approaches exist and should be incorporated into health systems' reaction to any problem. In healthcare systems it is not only the government that is responsible but also societal-based and/or private actors. The state, non-governmental organisations and the market are involved in the field of healthcare (Marmor and Okma 1998, Moran 2000, Powell 2007). Indeed, "The public's interest and the welfare of individual patients need attention by all parties" (Etheredge Jones 1991 p.94).

However, as a result government role in health system is to change. In the World Health Report 2000 it was stressed that it should fulfill the stewardship function taking the responsibility for the welfare of their populations and securing for the benefits the population might obtain from all kinds of health care providers, including private ones (WHO 2000, Saltman and Ferroussier-Davis 2000). This task should lead to development of new policy instruments such as regulation or contracting.

It is also important to define what exactly means "public" and "private" in any particular context. In health care much depends on the particular roles of various actors. Here it is important to separate between economic and legal issues. In economics usually three sectors are distinguished- public, private and non profit. They have their owned characteristics and specific features. The two principal divisions are profit motif and the way they are established.

Private providers are primarily motivated by the aim of making profit, and as a result their objectives do not coincide with the public goal of providing universally acceptable health care for the whole population. Such a mismatch of objectives results in particular problems in health systems, such as failure to address public health issues, first of all prevention, lack of integration with government health services, attraction of health professionals out of the public sector, distortions in provision and spatial distribution of facilities and equipment. In private sector access depends more on the ability to pay rather than need. Another important problem is quality of medical care as there is a conflicting empirical evidence on

whether quality in private health services is superior to public ones, most studies focusing on hospital care.

However, government failures should be discussed, too? To include among other things limited organisational capacity and a growing expansion of demand for health services. In this sense, new actors are motivated by their desire to fulfil the state's responsibilities in social provisions and by the government aiming to release some pressures on its budget. The negative impact on health services of decreasing public recourses has encouraged those who can afford it to switch to private sector (Reyes-Gonzalez).

At present one can witness strengthening of influence of private sector in both management and financing of services for people. In a market paradigm government can neither abolish nor ignore the private sector. It has regulate the behaviour of private providers in order to use their potential and capacity to benefit the public interest. It is the extent of government capacity to design, implement and monitor the regulatory system that will determine the success of the interaction between the two sectors. There are a variety of mechanisms that government can use to regulate the private sector.

PPM is not only a conceptual enterprise but can also be considered as a mechanism of interaction between the two sectors in question. Nowadays it is often discussed in relation with public private partnerships. There is no one widely accepted definition of public-private partnerships (PPP), often referred to as P3s. According to the WB it is "a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance". In public-private partnerships the private sector assumes a major share of the risks in terms of financing and construction and ensuring effective performance of the infrastructure, from design and planning, to long-term maintenance.

PPPs typically do not include service or construction contracts, which are categorized as public procurement projects, or the privatization of utilities where there is a limited ongoing role for the public sector. Such an approach develops

from the assumption that it is not only possible but necessary to increase cooperation between public and private sectors that is in their mutual interest and in the end in the interest of people. So, public and private sector can successfully co-exist in the provision of services that are of a public interest.

The specific role of NGOs in health care should also be noted, however they are not discussed in this paper as in Russia they are not yet developed in health sector provision.

Rothgang and Wendt generated typology that distinguished three core dimensions of the healthcare system: regulation, financing, and service provision, and three types of actors: state, societal, and private actors. Following it, we suggest that PPM in health care should be discussed from the three points of view, namely:

- regulation and governance;
- organizational structure of health care delivery;
- financing health care from various sources.

It is argued that for an individual patient much depends on who is financing, providing and regulating healthcare rather than the overall level of health system performance. In this paper we will focus on the latter two dimensions, discussing them in a particular context of Russian society. We selected these two dimensions as we wanted to look at areas of potential interaction between public and private sectors. In this sense legal regulation should be considered as a one-way process. Also it is important to go further to outcomes, to understand how PPM in these areas might influence health system outcomes for patients as well as its overall performance in selected areas.

Public/private mix in Russian health care: main characteristics.

In this section the organization of health care delivery and its trends in Russia are analysed. While in the Soviet Union Russian health care system was well known in the world as Semashko model. It was a budget medicine based on a network of the state owned health services that rendered services to population free of charge (at the point of delivery). With the beginning of transition to a market

based economy the system started to change and it was decided to switch to compulsory health insurance model.

Organisation and delivery

The PPM in health care delivery is characterized by a dominance of public health services yet the private sector is actively developing. However official statistics on the size of private sector are scarce. Quantitative date comes from either Rosstat, Russian statistical agency, or reports prepared by various consultant agency that however are distributed for money and are quite expensive. Nevertheless, even the data available indicates the gradual expansion of the private sector in Russian health care in terms of number of both health services and health personnel. Private health services are developing fast in certain segments of the industry (dentistry, plastic surgery, obstetrics).

Table 1.

Number of hospital and hospital beds

	2005	2010	2011	2012	2013	2014
	Total					
Number of hospitals	9479	6308	6343	6172	5870	5638
including non governmental	293	224	220	225	233	246
including private	…	115	116	127	143	166
Number of hospital beds, 000, total:	1575,4	1339,5	1347,1	1332,3	1301,9	1266,8
including non governmental	32,4	21,7	20,6	22,6	23,2	24,9
including private	…	4,1	4,1	6,5	7,9	11,0
Per 10 000	110,9	93,8	94,2	92,9	90,6	86,6
	Urban					
Number of hospitals	5820	4959	5048	4956	4775	4574
including non governmental	286	216	215	220	227	239
including private	…	110	113	124	140	162
Number of hospital beds, 000, total:	1365,9	1186,1	1198,3	1188,9	1164,7	1123,5
including non governmental	32,1	20,2	20,0	21,3	21,8	22,8
including private	…	3,4	3,7	6,1	7,4	9,9
Per 10 000	130,3	112,5	113,3	112,0	109,3	103,8

	Rural					
Number of hospitals	3659	1349	1295	1216	1095	1064
including non governmental	7	8	5	5	6	7
including private	…	5	3	3	3	4
Number of hospital beds, 000, total:	209,5	153,4	148,8	143,4	137,2	143,3
including non governmental	0,3	1,6	0,6	1,3	1,4	2,1
including private	…	0,68	0,46	0,46	0,46	1,02
Per 10 000	55,6	40,9	39,9	38,5	37,0	37,7

Source: Rosstat, 2015

The major trend in public sector health delivery network is so called optimization that implies both restructuring and shrinking of the number of health services one of the main arguments being economy on administrative expenses and rational use of resources. “Efficient use of hospital beds” in practice means first of all a reduction in their total number. Russia inherited a large hospital network and the number of beds is still quite high (Table 1), though constantly decreasing. But the question remains open if such a reduction is justified in terms of securing access taking into account spatial factor, including the share of rural population in Russia that is relatively high.

It should be noted that the logic of reforms changed during all these years. At the beginning the government just wanted to decrease first of all the number of hospital beds within the existing structures. However, at the beginning of 2000s serious efforts and money were put into modernization of health system in regions that was aimed to both improve technological aspects of health care delivery and restructure the system changing patients’ flows. This resulted in the fact that many health services all over the country were able get new equipment and renovated premises.

As the total number of hospitals decreased, the number of hospitals and hospital beds in the private sector has on the contrary, increased from 115 in 2010 to 166 in 2014 (table 1). As a result, their share in total number of hospitals also increased during the period in question from about 2% to 3%, respectively. The

number of hospital beds grew even faster – from 4,000 100 in 2010 to 11,000 in 2014, or almost threefold. It should be noted that private hospitals are established predominantly in urban areas.

As to primary care services- they are mostly organized as polikliniks- their numbers as well as capacity (measures as visits per shift) increased between 2010 and 2014 from 2753 to 3855, or by 30 % (Table 2). It should be noted that though the number of public primary care services fluctuated slightly their capacity increased as well.

Table 2.

Primary care services

	2005	2010	2011	2012	2013	2014
	Public					
Numbers	17172	12173	12270	12029	11841	12328
Capacity (visits per shift, 000)	3401.2	3420.7	3426.0	3445.9	3452.6	3491.5
	Non governmental					
Numbers	4043	3175	3357	3748	3858	4261
Capacity (visits per shift, 000)	192.5	226.6	246.0	270.7	283.5	319.1
	Including private					
Numbers	…	2753	2950	3363	3477	3855
Capacity (visits per shift), 000)	…	138.2	160.6	189.1	205.8	243.9

Source: Rosstat, 2015

In the current decade, there is a tendency of the numbers of doctors and nursing staff to decrease (see Table 3). The number of personnel working in the private sector is also growing both in absolute and relative terms. For the period 2005-2014 it increased almost twofold, from 173,1 thousands to 343,7 thousands. Thus, its share in total health employment also raised from 4 to almost 8%.

Table 3

Numbers of health care personell

	2005	2010	2011	2012	2013	2014
	Thousands					
Total	**4357,3**	**4464,0**	**4455,3**	**4435,4**	**4360,8**	**4344,4**
including:						
government	1837,7	2059,8	2283,0	2904,3	3218,0	3399,1
municipal	2242,6	2120,8	1845,7	1187,6	788,3	517,8
private	173,1	202,8	247,7	264,8	272,7	343,7
non governmental, including faith organisations	29,5	25,6	25,1	24,6	23,5	23,4

mixed Russian	56,9	38,5	39,0	37,1	34,9	35,0
foreign and mixed with Russian participation	17,5	15,7	14,8	17,0	22,6	24,3
			%			
Total	**100**	**100**	**100**	**100**	**100**	**100**
including:						
government	42,2	46,1	51,2	65,5	73,8	78,3
municipal	51,4	47,5	41,4	26,8	18,1	11,9
private	4,0	4,5	5,6	6,0	6,3	7,9
non governmental, including faith organisations	0,7	0,6	0,6	0,5	0,5	0,5
mixed Russian	1,3	0,9	0,9	0,8	0,8	0,8
foreign and mixed with Russian participation	0,4	0,4	0,3	0,4	0,5	0,6

Source: Rosstat 2015

Rosstat also provides information on average wages of health care workers employed in public and private (Table 4). Surprisingly, according to official statistics the difference is not as much as one would expect taking into account the relatively lower wages in public sector organisations. Even more, average wages in private sector since 2010 are lagging behind public sector. One of the reasons might be the problems with payroll statistics as it seems that in private health services accounting techniques may be used to lower it in order to lower social security taxes. As a result the biggest wages are recorded in health services belonging to either foreign or mixed foreign–Russian entities that are usually more careful with taxation issues.

Table 4.

Average nominal wages in health services by form of ownership

	2005	**2010**	**2011**	**2012**	**2013**	**2014**
	Rubles					
Average, total	5906	15724	17545	20641	24439	27068
including						
government	6603	18407	19615	21724	25139	27640
municipal	5172	12761	14717	17727	22123	24405
private	6844	18252	18409	20564	21219	23550
non governmental, including faith organisations	6101	13978	15547	18233	19404	21380
mixed Russian	7500	15523	18456	20959	23733	26355

foreign and mixed with Russian participation	11976	34376	36972	42930	50536	60145
	As share of average wage in health care services					
Average, total	100	100	100	100	100	100
including						
governmentt	112	117	112	105	103	102
municipal	88	81	84	86	91	90
private	116	116	105	99,6	87	87
non governmental, including faith organisations	103	89	89	88	79	79
mixed Russian	127	99	105	102	97	97
foreign and mixed with Russian participation	in 2,0 times.	in 2,2 times	in 2,1 times.	In 2,1 times.	in 2,1 ptimes	in 2,2 times.

Source: Rosstat 2015

Financing

In Russian the PPM in health care financing is more evident than in delivery structures. Health care in Russia is paid for from the two sources- public and private. Public sources include compulsory health insurance (CHI) and budget appropriations while private include voluntary private health insurance and out of pocket money.

Table 5

Health expenditures in Russia

	1995	**2000**	**2005**	**2010**	**2012**	**2014**
Total health expenditures, % GDP	5.36	5.42	5.21	6.83	6.88	7.07
Total government health finance, % total health expenditures	73.88	59.88	61.98	54.12	55.18	52.20
Total private expenditures, % total health expenditures	26.12	40.12	38.02	45.88	44.82	47.8
Government health expenditures, % total government expenditures	9.14	12.67	11.75	9.72	10.18	9.49
Social security expenditures, % total health expenditures	34.52	40.35	42.01	34.17	43.75	53.12
Private OPP, % private health expenditures	6	7	8	9	9	9

	4.66	4.70	2.39	4.39	4.92	5.92
Private OPP, % total health expenditures	16.89	29.97	31.32	43.30	42.55	45.85
Private prepayment plans, % private expenditures	6.0	8.06	8.24	4.58	4.3	3.50

Source: WHO, World health statistics, respective years. Дата обращения: 17.03.2017

In 1990s Russian GDP dramatically dropped due to disintegration processes and resources devoted by the state to the public needs had decreased. This was reflected in government health financing and as a result people have to mobilize private resources.

But what is more important, private expenses in all CIS members mostly consist of out-of-pocket payments (OPP). This means that people pay cash at the moment of receiving medical treatment. The share of OPP amounted to almost 96% of private and 46% of total health expenditures in Russia in 2014.

The practice of informal payments became widespread in Russia as in other post Soviet countries in early 1990s leading to formation of “shadow health economy” (Lewis M. 2007).They include institutional or individual payments to suppliers, in kind or in cash, which are made outside the official channels or paid for services that should be covered by the health care system. With the reduction of government spending and low wages paying medical staff directly has become almost a norm. However it changed with the official introducton of the right for state health services to charge fee for medical treatment provided extra to a guaranteed package. In Russia all public health services especially hospitals have a special department though which a patient can pay and get services not included into free government guaranteed through CHI. However, there is a big concern-supported by evidence - that health services often make patients pay fees for services that should be provided free of charge (to overcome waiting lists, to visit a certain specialist). The situation is even more complicated as the paid services are rendered in the same facility, using the same equipment, etc.

The idea of privatization of public health services is not popular in Russia. Currently, civil society is concerned with PPP as mean of a hidden privatization.

There are grounds for such concerns as typically in all PPP agreements in health care an arrangement is included on introduction private wards in public hospitals.

Public/private mix in Russian health care: problems and outcomes

In the PPM in Russian health care the tendency is observed to increase the role of private finance and to a lesser extent, delivery of health care. As a result,

- share of private finance in total health expenditures is significant;
- OPP constitute the major share of private health expenditures;
- network of private provides both in primary and hospital care is gradually expanding first of all in urban areas.

However, in general the share of "private" in PPM in Russian health care is much more pronounced in financing while in provision it is rather marginal. At that public health services can officially offer services for fee while private health services recently got a right to enter CHI and thus treat patients receiving reimbursement from CHI money.

It is argued here that in fact in Russia a situation in health system might be named as *inverse quasi-markets*. Normally in quasi markets the demand is determined by the state money while in the field of supply health services of various form of ownership compete for public money. In Russian inverse quasi markets it seems that the demand is more created by the private money and public health services "compete" formally or informally for private finance with private and non governmental providers.

It is quite difficult to evaluate the impact of the composition of PPM on health care system functioning. Typically two problems attract attention in the society when outcome of health system performance are discussed, namely access and quality of care. The findings of recent research on health expenditure in 13 OECD countries from 1981 to 2007 suggest that the degree to which health services are socialized is regarded as the product of a trade-off between the desire to redistribute income through the fiscal system and the losses some citizens will incur when the public health care system expands. Greater income inequality and

population aging were found to be associated with a smaller share of public health expenditure in total health expenditure. Private health insurance tends to erode the political support for the public health care systems in countries with private *duplicate* health insurance, but not in countries with private *primary* health insurance (Mou 2013).

Recently in Russian health care a number of initiatives were undertaken aimed to improve both access and quality of care. High technology treatment should be mentioned as well as construction of pre-natal centers. Modern equipment was purchased and a number of facilities renovated. The number of health status indicators have improved, first of all life expectancy at birth, though some indicators are still quite high according to developed countries standards.

The expansion of private finance and provision definitely increased patients' ability to exercise choice in health system in a sense that people can now seek medical treatment choosing particular health service or particular consultants. This also helps to lessen the burden on public system as some patients now may receive treatment in private health services.

However, a serious discrepancy is observed between the certain positive results, that are officially fixed in statistics and reports of the governmental bodies such as Ministry of Health, on one hand, and population attitudes to health system and self rated health. Sociological surveys reflect that the majority of respondents are not satisfied with health system and their health status.

Table 6.

Are you satisfied with the existing health system in Russia?

	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Definitely yes/скорее да	11	14	11	12	17	14	18	14	15	16	15	20	31
Nither yes nor no	23	20	22	19	21	20	23	22	22	22	22	…	…
Скорее нет/ Definitely no	62	65	65	68	59	64	58	60	59	57	61	77	64
Difficult to say	4	1	2	1	3	2	1	4	4	5	2	4	4

Source: Levada centre, 2015.

In order to evaluated the outcomes of emerging PPM in Russian health care its financial and institutional implications should be placed into a broader societal context.

In course of transition in Russia the role of the state in society as well as in health care has changed with the emergence of strong individual ideology. (Chubarova Grigorieva, 2013). On the crest of the democratic up tide of the late 1980's and early 1990's the notion prevailed that the state should withdraw from direct participation in the economy by providing space for market self-regulation. General principles of market relations have been automatically transferred to the social sector, including health care. In the early years of reform hopes were high that the market will regulate the relationship between all the actors of the health system hat led to decreasing role of government in health care in the post-Soviet Russia . The Soviet state was regarded as too paternalistic for the market economy, so the main course had been taken to reduce state intervention in social sector and to increase individual responsibility for well-being and health.

Among the trends that contributed to increased individual responsibility the following should be mentioned. First, the resistance of already established organizational structures in health care, meaning the formation of new system of interests, second the changing role of medical profession that seems to be adopting quite well to modern market realities, and third, stress on behavioral factors in understanding social determinant of health and evident underestimation of such social factors as income, employment, education, housing. (Chubarova 2010).

Thus, it is suggested here that health care financing develops along increasing of "individual", rather than just private financing. Even more, such a big share of OPP as predicted by some research is unlikely to change dramatically in coming years. As a result everyone pays for himself/herself and the system itself becomes individualized. An important consequence is that virtually no redistribution happens in health financing that in fact undermines the basis of social solidarity, when rich pays for the poor and those who are healthy pay for those who are ill.

The problem is aggravated by high levels of inequality as well as complex situation with poverty. The Gini coefficient is 4.1 in Russia that allows to consider Russian society as highly polarized. For the period 2005-2013, according to UN data, quintile coefficient amounted to 7.3, and Palma coefficient was 1,8.

It is a well known fact that without redistributive mechanisms being introduced high income inequality means also inequality in other areas of social life, including access to health care. In such conditions the decline in the share of state financing is likely to make it difficult for people to access health services.

The sociological surveys show that the majority of Russian are not satisfied with their health status and performance of health system. Probably this is the reason why about 50% of Russian do not visit health services in case of having a health problem preferring self medication (Rosstat 2014).

In such circumstances the effective use of public funds is high on the health policy agenda in Russia. However, the programme-based measures that are adopted in Russia aim at solving particular problems in health system, based either on epidemiological or resource approach, does not seems to contribute much to overall health system performance (lacking systematic vision and proper sequencing, creating gaps).

Lack of public resources allocated to health care in Russia is likely not only to impede assess to health care by a large population segments but to change relevant policies. Therefore, the role of private finance seemed to be institutionalized, or deeply embedded into existing health systems. Even more, it is not just supported by existing delivery structures but such structures are likely to develop based on the notion of "individual health finance". Government seems to be ready to shift responsibilities for health care to people as a way to solve a problem of health financing. Thus, the stress on individual health responsibility based on a behavioral approach. In such a situation building health systems on "basic packages" opens a possibility for the state to easily change the composition of such a package to increase individual finance.

It is argued here that if Russian government is still prepared to fulfill its health responsibilities, other collective forms of prepayment need to be developed if universal health coverage is to be a reality.

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